DISABILITY RIGHTS MAINE

March 18, 2025

Senator Henry Ingwersen, Chair
Representative Michele Meyer, Chair
Joint Standing Committee on Health and Human Services
Cross Office Building, Room 209
Augusta, Maine 04333

Re: Testimony in support of LD 769: An Act Regarding Access to Behavioral Health Supports for Adults with Certain Disabilities

Dear Senator Ingwersen, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services:

My name is Staci Converse and I am a managing attorney at Disability Rights Maine. DRM is Maine's designated Protection and Advocacy Agency, and our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine. Thank you for the opportunity to provide testimony in support of LD 769.

I am here today to testify in strong support of this legislation, which will eliminate the planned use of restraints on adults with intellectual disabilities and autism, except in emergency situations to prevent imminent harm. Restraints are not a treatment for behavior, and place both caregivers and the people they serve in physical danger, and create trauma. Because we know better, we must do better.

For far too long, people have believed that individuals with developmental disabilities are different in a way that justifies the use of restraints as part of their treatment. This is simply not true. Restraints are harmful, and they sanction a culture of violence that has no place in a system designed to support and empower people with disabilities.

It is worth noting that people with developmental disabilities are the only individuals in Maine who can be restrained in non-emergency situations as part of a behavior management plan, outside of institutional settings. The planned use of restraints is not permitted in OADS programs serving people with brain injuries. It is prohibited by the

Rights of Recipients of mental health services. There is absolutely no justification for treating people with developmental disabilities differently.

Along with others testifying today, I was part of the stakeholder group that spent over a year examining different systems of care in other states. We learned that ending the use of restraints is possible—because other states, such as Kentucky, have done it. This bill presents an incredible opportunity, and Maine can learn much from the states that have come before it in eliminating restraints

The harm caused by restraints extends far beyond the immediate physical and emotional trauma. Restraints blur the line between protection and abuse, creating a system in which individuals with disabilities are expected to accept that being physically controlled—even assaulted—is sometimes "for their own good." How can we expect that a person who is regularly subjected to being physically held against their will to distinguish between a "sanctioned" act of force and outright abuse?

We know from our work that many people with DD are subject to plans that permit restraints. Plans that are never discontinued because providers become reliant on them to manage behavior, and because there is no incentive to phase them out."

We anticipate that opponents will argue that restraints are necessary to keep people safe and will offer extreme, highly unlikely hypotheticals to claim this legislation will not work. This reflects a fundamental misunderstanding of the bill. This legislation does not prohibit all restraints. It prohibits planned restraints, approved pursuant to a behavior plan. It prohibits sending the message to providers and those who receive services that regular restraints will be tolerated and permitted to be implemented in perpetuity. It does not prevent staff from stopping a person attempting to jump in front of a bus. It does not prevent intervention when someone is engaging in self-injurious behavior so severe that it could lead to blindness. The purpose of this legislation is to end the use of restraints as part of a planned, ongoing practice—not to remove emergency protections when they are truly needed.

It is also important to recognize the limited scope of these plans. Out of the approximately 7,500 individuals served by the Office of Aging and Disability Services (OADS), only about 100 have behavior plans. However, these 100 plans set the tone for the entire system. By allowing planned restraints, the state is sending a dangerous message: that it is not only permissible but therapeutic to physically control and harm people with developmental disabilities. This must end. We commend OADS for recognizing this and taking steps toward change.

I have attached a friendly amendment to this legislation. I want to highlight the key changes in this proposed amendment:

- **Application to Adults Only**: This legislation applies **only to adults**, but we strongly believe that the prohibition on the planned use of restraint should extend to children as well. Unlike with adults, there was no stakeholder group convened to develop legislation for children. This amendment would establish

such a group and charge it with making recommendations to the committee on how to extend these protections to children.

- **13-A(A)**: This amendment allows a person receiving services to request a positive behavioral health plan.

- **13-A(B) & (C):** These amendments clarify the distinction between a **positive support plan** and a **behavior modification plan**. This distinction is crucial to ensure that supports remain person-centered and not coercive.

- **Self-Advocate Compensation**: In 13-A, we recommend that any self-advocate who is contributing their time and is not otherwise paid should be compensated for their participation.

- **13-B(A)**: This subsection differentiates between a **safety plan** and a **behavior modification plan.** Too often, we see plans justified under the guise of "safety," when in reality, they impose behavioral restrictions. There is a critical difference:

    - A **safety plan** supports a person without limiting their free will (e.g., a harness in a wheelchair that helps with body positioning).
    - A **behavior modification plan** restricts autonomy (e.g., a harness in a wheelchair used to prevent a person from getting out of the wheelchair).

  Without clarity between restrictions to address behavior (which is always in the name of safety) and devices used for safety due to non-behavioral reasons, there would be no discernable difference between behavior plans and safety plans, erasing important protections.

We know better. Other states and other programs in Maine have proven that a system without planned restraints is possible. Now, it is Maine's turn to do better. I urge you to support this legislation along with the proposed amendment, and take a critical step toward a safer, more respectful, and more just system of care for individuals with developmental disabilities and autism.

I am happy to answer any questions you have and plan to be at the work session.

Sincerely,

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Staci Converse, Esq.
Managing Attorney
Disability Rights Maine

An Act Regarding Access to Behavioral Health Supports for Adults with Certain Disabilities

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 34-B MRSA §5605, sub-§12, ¶E, as enacted by PL 2011, c. 186, Pt. A, §26, is repealed.

Sec. 2. 34-B MRSA §5605, sub-§13, as amended by PL 2013, c. 500, §1, is further amended to read:

13. Behavioral health support, modification and management for children. Behavior modification and behavior management of and supports for a person who has not attained 18 years of age with an intellectual disability or autism and who is not a patient in a psychiatric unit of an acute hospital or a psychiatric hospital as defined in section 3801, subsection 7-B are governed as follows.

A. A person who has not attained 18 years of age with an intellectual disability or autism may not be subjected to a behavior modification or behavior management program to eliminate dangerous or maladaptive behavior without first being assessed by a physician to determine if the proposed program is medically contraindicated and that the dangerous or maladaptive behavior could not be better treated medically.

A-1. Support programs may contain both behavior modification and behavior management components.

A-2. The following practices are prohibited as elements of behavior modification or behavior management programs:

(1) Seclusion;

(2) Corporal punishment;

(3) Actions or language intended to humble, dehumanize or degrade the person;

(4) Restraints that do not conform to rules adopted pursuant to this section;

(5) Totally enclosed cribs or beds; and

(6) Painful stimuli.

B. Behavior modification and behavior management programs may be used only to correct behavior more harmful to the person than the program and only:

(1) On the recommendation of the person's personal planning team; and

~~(2) For an adult 18 years of age or older, with the approval, following a case-by-case review, of a review team composed of a representative from the department, a representative from the advocacy agency designated pursuant to Title 5, section 19502 and a representative designated by the Maine Developmental Services Oversight and Advisory Board. The advocacy agency representative serves as a nonvoting member of the review team and shall be present to advocate on behalf of the person. The department shall provide sufficient advance notice of all scheduled review team meetings to the advocacy agency and provide the advocacy agency with any plans for which approval is sought along with any supporting documentation; and~~

(3) ~~For a child under 18 years of age, with~~ With the approval, following a case-by-case review, of a review team 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.

The department shall provide sufficient advance notice of all scheduled review team meetings to the advocacy agency and provide the advocacy agency with any plans for which approval is sought along with any supporting documentation. Until rules are adopted by the department to govern behavioral treatment reviews for children, the team may not approve techniques any more aversive or intrusive than are permitted in rules adopted by the United States Secretary of ~~the United States Department of~~ Health and Human Services regarding treatment of children and youth in nonmedical community-based facilities funded under the Medicaid program.

Sec. 3. 34-B MRSA §5605, sub-§13-A is enacted to read:

13-A. Behavioral health support, modification and management for adults. Behavioral supports for an adult with an intellectual disability or autism who is not a patient in a psychiatric unit of an acute hospital or a psychiatric hospital as defined in section 3801, subsection 7-B are governed as follows.

A. An adult with an intellectual disability or autism may have a positive behavioral health support plan if recommended by the individual's person-centered support team or requested by the individual. If the positive support plan is to address dangerous or maladaptive behavior, it must be preceded by an assessment by a medical practitioner, as defined in section 3801, subsection 4-B, to rule out medical reasons for the behavior.

B. A positive behavioral health support plan is designed to support the adult to participate meaningfully in that adult's community life cannot include a waiver of any rights provided in this section and may be implemented upon recommendation of the adult's personal planning team.

C. A modifying behavioral health support plan is designed to modify or redirect the adult's behavior and may include a waiver of rights only with the informed consent of the adult subject to the plan and must be submitted to the department for approval prior to implementation. The plan must be reviewed and approved by a licensed clinical psychologist designated by the department.

D. The following practices are prohibited as elements of positive behavioral health support plans, behavior modification or behavior management programs for adults:

(1) Seclusion;

(2) Corporal punishment;

(3) Actions or language intended to humble, dehumanize or degrade the person;

(4) Planned use of restraints;

(5) Totally enclosed cribs or beds; and

(6) Painful stimuli.

The department shall convene a support and safety committee on a quarterly basis to review data regarding the number and type of plans implemented for adults under this subsection. The committee must include, but is not limited to, a self-advocate, a representative of the advocacy agency designated pursuant to Title 5, section 19502, a member of the Maine Developmental Services Oversight and Advisory Board established pursuant to Title 5, section 12004-J, subsection 15 and the licensed clinical psychologist, if any, designated by the department under paragraph C. If not otherwise compensated for their time, the self-advocate shall be paid a reasonable stipend by the department.

For the purposes of this subsection, "adult" means a person 18 years of age or older; "modifying behavioral health support plan" means a support plan that outlines strategies to manage behavior concerns and may include both positive and negative interventions; and "positive behavioral health support plan" means a

behavioral health support plan that emphasizes using positive reinforcement and proactive strategies to address behaviors that negatively impact the health, safety and well-being of the person.

Sec. 4. 34-B MRSA §5605, sub-§13-B is enacted to read:

13-B. Safety devices for adults. The use of a safety device for an adult with an intellectual disability or autism is governed as follows.

A. For the purposes of this subsection, "safety device" means an implement, garment, gate, barrier, lock or locking apparatus, video monitoring or video recording device, helmet, mask, glove, strap, belt or protective glove, the effect of which is to reduce or inhibit the adult's movement with the sole purpose of maintaining the safety of the adult. Safety devices shall not be used as a means of behavior modification.

B. The use of a safety device must be pursuant to a written recommendation from a licensed physician, certified nurse practitioner or licensed physician assistant.

C. The use of a safety device must be approved by the adult's personal planning team, and that approval must be recorded in a document that is part of the adult's planning record.

D. The adult or the adult's guardian must consent to the use of the safety device.

E. When a safety device is in use and that safety device may affect other adults residing in the home or participating in the program by restricting their rights, accommodations must be identified and implemented to minimize the effect on the other adults. The personal plan of each adult affected by the use of the safety device must indicate how that adult will be supported to minimize the negative effect of the restriction.

F. When a video monitoring device or video recording device is in use and other adults residing in the home or participating in the program may trigger or appear on the video monitoring device or video recording device, the consent of that adult must be obtained.

Sec. 5. 34-B MRSA §5605, sub-§14-A, as amended by PL 2011, c. 657, Pt. EE, §10, is further amended to read:

14-A. Restraints for children. A person who has not attained 18 years of age with an intellectual disability or autism is entitled to be free from restraint unless:

A. The restraint is a short-term step to protect the person from imminent injury to that person or others; or

B. The restraint has been approved as a behavior management program in accordance with this section.

A restraint may not be used as punishment, for the convenience of the staff or as a substitute for habilitative services. A restraint may impose only the least possible restriction consistent with its purpose and must be removed as soon as the threat of imminent injury ends. A restraint may not cause physical injury to the person receiving services and must be designed to allow the greatest possible comfort and safety.

Daily records of the use of restraints identified in paragraph A must be kept, which may be accomplished by meeting reportable event requirements.

Daily records of the use of restraints identified in paragraph B must be kept, and a summary of the daily records pertaining to the person must be made available for review by the person's planning team, as defined in section 5461, subsection 8-C, on a schedule determined by the team. The review by the personal planning team may occur no less frequently than quarterly. The summary of the daily records must state the type of restraint used, the duration of the use and the reasons for the use. A monthly summary of all daily records

pertaining to all persons must be relayed to the advocacy agency designated pursuant to Title 5, section 19502.

Sec. 6. 34-B MRSA §5605, sub-§14-E is enacted to read:

14-E. Restraints for adults. An adult with an intellectual disability or autism is entitled to be free from restraint unless the restraint is an emergency short-term step to protect the adult from imminent injury to that adult or others. The use of restraint must be documented in accordance with the department's reportable event requirements.

Resolve, Directing the Department of Health and Human Services to Establish a Stakeholder Group to Study Behavioral Health Supports for Children with Intellectual Disabilities and Autism

Sec. 1. Department of Health and Human Services to establish stakeholder group to study the law governing access to behavioral health supports for children with intellectual disabilities and autism, Resolved: That the Department of Health and Human Services shall convene a stakeholder group to study the law governing access to behavioral health supports for children with intellectual disabilities and autism, The study must examine:

1. The usage of restraints in non-emergency situations; and

2. The process by which behavioral health support, modifications and management for children are reviewed, approved and monitored.

The department shall include in the stakeholder group a youth self-advocate, an adult self-advocate with knowledge of the impact of the use of restraints, a representative from agency designated pursuant to Title 5, section 19502, a representative from the Center for Community Inclusion and Disability Studies, and a representative from the Maine Association of Community Service Providers.

Sec. 2. Report. Resolved: That the Department of Health and Human Services shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than February 1, 2026 on the study under section 1. The joint standing committee may report out legislation related to the report to the 133rd Legislature in 2026.

SUMMARY

This bill amends the law governing access to behavioral health supports for adults with an intellectual disability or autism by replacing a complex multiparty review process with a clinical review requirement. It also removes the authority to use restraints on adults except as an emergency short-term step to protect the adult from imminent injury to that adult or others. It also codifies existing rules on safety devices, making it clear that such devices are not considered positive behavioral health support plans and therefore do not require the same level of review as positive behavioral health support plans. Also, to conform with current practice, the bill repeals a provision of law regarding the authority of providers of residential services to establish house rules in residential units owned or operated by the provider.