

**STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES**

Procedure No: 1.E.PR.002

Subject: Behavior Support Plans

Section: Health and Safety

Issue Date: April 11, 2006

Effective Date: Upon Release

Revised: July 1, 2009

A. Purpose

The purpose of this policy is to assure that each person placed or treated under the direction of the Commissioner in any public or private facility, or who receives HCBS waiver services in his/her own or family home, shall be protected from harm and receive humane and dignified treatment, which is adequate for such person's needs and for the development of such person's full potential at all times in regard to the design, approval and implementation of behavior support plans. It is the intention of the department to promote and use the most humane and dignified approaches to supporting individuals who have challenging behaviors. The Department is committed to ensure that effort is made to introduce positive behavioral programming and supports that enhance the unique aspects of each individual supporting them to live a full life of choice and inclusion. The design, approval and implementation of behavior support plans will reflect the values of the department to provide the least restrictive setting and interventions for all who are served.

In addition, this policy is issued to promote a statewide consistency regarding the use, documentation, review and approval of aversive procedures employed with individuals served by the Department of Mental Retardation and to assure consistent implementation of Behavior Support Plans.

B. Applicability

This procedure applies to all individuals placed or treated under the direction of the Commissioner. This includes individuals receiving services in or from DDS operated, funded and/or licensed facilities, including ICF/MR, CLA, CTH, Day Services and DDS Individualized Home Supports provided in any setting and/or any DDS funded service regardless of where the individual lives. It applies to individuals receiving any HCBS Waiver Services where paid staff are required to carry out a behavioral intervention that utilizes an aversive, physical, or other restraint procedure and/or staff funded by the DDS who are required to pass/give a behavior modifying medication, regardless of where the individual lives. This procedure applies to individuals receiving services from the DDS Voluntary Services program if they are placed in an in-state DDS operated, funded and/or licensed facility. It also applies to any individuals who receive ongoing, planned psychiatric supports where behavior modifying medication is prescribed by the Psychiatrist regardless of where the individuals live and whether or not they are receiving DDS Waiver Services.

This procedure does not apply to those receiving DDS Respite Services only, those exempt from Program Review Committee/Human Rights Committee (PRC/HRC) review, and those who reside in long-term care facilities licensed, funded and/or overseen by other state agencies.

C. Definitions

Appropriate Supervision & Release-Time: During the use of all restraint, the individual must be checked at least every 15 minutes to assure their safety and well-being. Individuals must also be released from restraint for a minimum of ten minutes after every hour of restraint and provided with an opportunity for exercise, liquid intake, and toileting. (Such release and exercise may be done one limb at a time if total release would jeopardize the safety of the individual or others.)

Aversive Procedure: A procedure that contains the contingent use of an event or device that may be unpleasant, noxious, or otherwise cause discomfort to (1) alter the occurrence of a specific behavior or to (2) protect an individual from harming him or herself or others and may include the use of physical isolation and mechanical and physical restraint. This also includes the use of chemical restraints and the use of restrictive procedures such as escorts (except escorts like 'guide along' that are met with little or no resistance from the individual) physical isolation, response cost, over-correction, restitution, and other similar techniques.

Behavioral Support Plan: A written document developed to address an individual's behaviors that interfere with the implementation of the goals and objectives identified in the Individual Plan or to track and monitor target behaviors. The plan shall include identification of specific target behaviors and a plan for tracking and monitoring responses. These procedures shall be included in the plan when the use of aversive procedures to protect the individual from harming him or herself or others is reasonably anticipated to be needed through the use of data.

CAMRIS: Connecticut Automated Mental Retardation Information System, the Department's mainframe computer system.

Commissioner: The Commissioner of Developmental Services.

Data: Quantitative measures of an individual's performance with respect to a target behavior or desired outcome compared to baseline or other comparator. Such data may be formatted in tabular or graphic presentation(s) to determine whether various treatments are effective over time.

Emergency: An acute or urgent situation in which a physician has determined that treatment (i.e. medication) must be started immediately or a situation in which a caregiver determines that immediate intervention (i.e. emergency physical, mechanical and/or chemical restraint) is necessary to protect an individual from harming him or herself or others.

Functional Analysis: The systematic assessment of an individual's behavior that yields: (1) an operational description of the undesirable behaviors; (2) the ability to predict the times and situations in which the undesirable behavior is likely to occur across the full range of typical daily routines; (3) a description of the function that the undesirable behavior serves for the individual; and (4) an understanding of the environmental, interpersonal, and other ecological factors that shall be considered in the development of an effective programmatic response to the behavior.

Human Rights Committee (HRC): A group of people who are not employees of the department, who provide monitoring to assure the protection of legal and human rights of individuals with mental retardation. Membership may include a physician, a lawyer, a parent, staff of contracted agencies, or other volunteers. A DDS employee shall act as a liaison between the HRC and the region or Training school. The HRC shall act as an advisory group to the Regional or Training School Director.

Mechanical Restraint: Any apparatus used to restrict movement, including any device (e.g. helmets, mitts, and bedrails) used to prevent self-injury. This excludes mechanical supports designed by a physical therapist and approved by a physician that are used to achieve proper body position or balance, protective devices that are approved by a physician for specified medical conditions (e.g. helmet used to protect an individual from injury due to a fall caused by a seizure), and mechanical devices that can be removed by the individual at their choosing (e.g., helmets, mitts).

Physical Isolation: The process by which an individual is separated from others and is physically not allowed to leave (i.e., prevented through physical means such as physically blocking the door) that area until defined criteria are met. (This does not include occasions when an individual is sent to a room with verbal prompts and is not physically prevented from leaving.)

Physical Restraint: Any physical hold used to restrict individual's movement or to protect an individual from harming him or herself or others. This excludes physical interventions that are met with little or no resistance from the individual such 'guide along techniques' or holds that are used as guidance to teach an individual a skill, e.g. hand over hand techniques.

Physical or Mechanical Restraint Employed as a Medical Restraint: There are two types of medical restraint (A and B). Type A is physical, mechanical, or chemical restraint that is used to safely administer medical or dental services. For example: physically holding a person's arm to draw blood, suture, etc; or, chemical sedation prior to dental or MD appointment. Type B is physical, mechanical, or chemical restraint that is used to aid a healing process and prevent an otherwise acceptable behavior. For example: use of chair with tray to prevent person from walking while a sprained/broken ankle heals.

Planning and Support Team (PST): Individuals and the people who are important in their lives. At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, and persons whom the individual requests to be involved in the individual planning process including the individual's family and/or advocate, the individual's case manager and the support staff and others who know the individual best. Depending upon the individual's specific needs, professional staff who are providing supports and services to the individual may be involved in the individual planning process and in attendance at the individual planning meeting.

Positive Behavioral Supports: An integrated approach to teach an individual adaptive and socially appropriate skills and competencies. Supports may include teaching strategies and/or environmental supports to increase adaptive behaviors. These approaches should treat the individual in a respectful, age appropriate manner, should be built into the individual's daily routine, and should occur in a natural context. The individual and his or her family, guardian, advocate, and support staff should be involved in the design of the positive behavioral supports.

Positive Reinforcement: A contingent event that that increases a response frequency.

Program Review Committee (PRC): A group of professionals, including a psychiatrist, assembled to review individual behavior treatment plans and behavior modifying medications to assure that they are clinically sound, supported by proper documentation and rationale, and are being proposed for use in conformance with department policies. The PRC shall act as an advisory group to the Regional or Training School Director.

PRC/HRC Review: A Program Review Committee/Human Rights Committee review. The PRC review includes a member of the Human Rights Committee is present to represent and act on behalf of the Human Rights Committee.

D. Standards Of Practice For Behavioral Programming

Program Author Qualifications

Any individual given the responsibility to develop behavioral programming for an individual will at a minimum meet one of the following requirements (Note- This outline of author qualifications is consistent with DDS Provider Qualifications for those providing Clinical Behavioral Support Services):

1. State licensure as a psychologist as prescribed in CGS 383 or
 2. State Licensure as a Clinical Social Worker as prescribed in CGS 383b or
 3. Board Certification as a Behavior Analyst (BCBA) or Board Certification as an Associate Behavior Analyst (BCABA) or
 4. A Masters or doctoral degree in Psychology, Social Work, Special Education or Applied Behavior Analysis or Licensure as a counselor as prescribed in CGS 383a or 383c — and
 - a. Coursework in Human Behavior and
 - b. Coursework and/or experience in developing behavioral treatment plans and
 - c. At least 2 years of experience providing behavioral supports to people with intellectual disabilities.
- OR-
5. A Bachelor's degree in psychology, special education or other related field and review and approval by the DDS Behavioral Support Services Panel.
 - a. Coursework in Human Behavior and
 - b. Coursework and/or experience in developing behavioral treatment plans and
 - c. At least 3 years of experience providing behavioral supports to people with intellectual disabilities.

Program Author Approach

Any individual who authors behavioral programming will adhere to the following guidelines:

1. The clinician objectively solicits, honors and respects the unique needs, values and choices of the persons being served
2. The clinician communicates fully and honestly in the performance of his/her responsibilities and provides sufficient information to enable individuals being supported and others to make their own informed decisions to the best of their ability.
3. The clinician protects the dignity, privacy and confidentiality of individuals being supported, and makes full disclosure about any limitations on his/her ability to guarantee full confidentiality.
4. The clinician is alert to situations that may cause a conflict of interest or have the appearance of a conflict. When a real or potential conflict of interest arises the clinician not only acts in the best interest of individuals being supported, but provides full disclosure.
5. The clinician seeks to prevent, and promptly responds to signs of abuse and/or exploitation, and does not engage in sexual, physical, or mental abuse.
6. The clinician assumes responsibility and accountability for personal competence in practice based on the professional standards of his/her respective field, continually striving to increase professional knowledge and skills and to apply them in practice.
7. The clinician exercises professional judgment within the limits of his/her qualifications and collaborates with others, seeks counsel, or makes referrals as appropriate.

8. The clinician fulfills commitments in good faith and in a timely manner.
9. The clinician conducts his/her practice with honesty, integrity, and fairness.
10. The clinician provides services in a manner that is sensitive to cultural differences and does not discriminate against individuals on the basis of race, ethnicity, creed, religion, sex, age, sexual orientation, national origin, or mental or physical disability.

Components of Behavioral Programming

All programs designed to address maladaptive behavior require a Functional Behavior Assessment (FBA) as a necessary first step in developing a treatment plan. The FBA should include not only an assessment of antecedents and consequences, but should also take into consideration the individual's history with special attention paid to factors that may have been crucial to the development of this behavior.

1. Functional Behavior Analysis (FBA)
 - a. What is driving the behavior i.e. what function might this behavior be serving?
 - b. How long has this behavior been exhibited
 - c. Is this possibly a variant of an older behavior?
 - d. Are there current factors in a person's life to which they may be reacting?
 - e. What skill deficits might this behavior be compensating for? (Task analyze each skill into the sub skills necessary to achieve this goal.)
2. Behavior Program elements based on FBA
 - a. Rationale for this approach to the behavior. — Behavioral goals and objectives specifically based on what was learned from the FBA
 - b. Develop strategies to achieve each of the sub goals
 - c. Methods for teaching socially appropriate alternative behaviors to help people cope to meet their needs .
 - d. A description of antecedents that indicate the behavior is about to occur.
 - e. Methods employed to redirect problem behaviors before or when they occur.
 - f. The hierarchy of interventions to be used if problem behaviors escalate
3. Data Collection
 - a. Data on negative behaviors being targeted by the medication or aversive technique — How are those negative behaviors operationalized, i.e. what will the support person see
 - b. Data should be kept on the skills that are being built as an alternative to the negative behaviors.
4. Data should be graphed with annotations indicating changes in the medication or behavior support plan.
5. Changes in the data collection system should be graphed with a new baseline.
6. Data should be shared with all support staff as well as with all physicians prescribing medication.
 - a. Changes in medication should be based upon an assessment of the longitudinal data.
 - b. Data should be reviewed periodically to determine if changes in the behavior program are needed.

E2 – Guiding Principles

The need for a review and the length of the review cycle is determined by the Program Review Committee. Once the Program Review Committee has either checked the box 'PRC Review Not Required', or has established a review cycle, a Planning & Support Team/PST does not need to return to the PRC unless there is a change in diagnosis, significant change in medication type, significant change in medication dosage exceeding FDA range, or a significant increase in problem behaviors related to the use of medication and/or the behavioral intervention.

Restraints / Aversive Procedures

Any use of an Aversive Procedure must have an initial review by the Program Review Committee

Although the Regional PRC can request a review at any time, and can set any re-review timeframe they feel is appropriate, if it is determined by the PRC that an individual's challenging behaviors are stable, i.e. in a 'steady-state', then the length of time between PRC reviews will be determined by the PRC. This might include not coming back to the PRC unless there is a change in the Behavior Modifying Medication's, or behavioral data increase, or additional restrictive interventions is felt to be necessary. Future PRC reviews will be evaluated in light of previous PRC reviews and/or the behavioral data that has been developed over time.

Exemptions

Exempt criteria will be based on type and level of support for the person, specifically looking at how the individual manages their medical care. If a person has a guardian, they can be exempt if they meet the exempt criteria and the guardian approves. If a person does meet the exempt criteria, and there is no guardian, then the Planning & Support Team/PST for the person and the Regional Exempt Committee must agree on the exemption.

E2. Implementation

1. Approval For Behavior Support Plans That Do Not Include Aversive Procedures
 - a. The planning and support team identifies the need for a behavior plan based on a functional analysis and other relevant medical review.
 - b. Staff members with appropriate training, experience and competency are assigned to conduct a functional analysis and develop a behavior support plan.
 - c. The planning and support team approves the plan.
 - d. The plan is implemented and a copy of the plan is filed in the client's file on the living unit.
 - e. The Planning and support team reports plans that may be viewed as aversive to the Program Review Committee before the plans are implemented.
 - f. The case manager monitors the plan on an ongoing basis and the planning and support team reviews the plan as outlined in the "Overall Plan of Services" Procedure.
2. Approval Of Behavior Support Plans That Include Aversive Procedures
 - a. Aversive procedures shall be reviewed and approved as follows:
 - i. The planning and support team identifies the need for a behavior plan that includes the use of aversive procedures.
 - ii. Staff members with appropriate training, experience and competency are assigned to conduct a functional analysis and develop a behavior support plan. All plans must

include components designed to increase positive behavior (i.e., must include positive behavioral supports).

- iii. The planning and support team collects and submits required information to the PRC/HRC. Knowledgeable planning and support team member(s) will present the proposed plan to the Program Review Committee for review and approval prior to implementation of the plan (as per I.E. PO 004 and I.E. PR 004).
- iv. The Planning and support team shall assure that the individual and the individual's parent, guardian, or advocate are informed of:
 - (a) The [target behavior and] goal of the plan, including adaptive skill(s) to be taught and target behavior(s) to be reduced
 - (b) The aversive or individual control procedure under consideration
 - (c) The possible side effects of using the procedure.
 - (d) The consequences of not administering the procedure
 - (e) Documentation of less aversive procedures that have been found ineffective
 - (f) Expected duration of the plan
 - (g) The Program Review and Human Rights Committee process
 - (h) Procedures for appeal (i.e., as required by C.G.S. 17a-210)
- v. The individual, parent, guardian or advocate may attend the Program Review Committee meeting for the purpose of hearing the presentation and presenting any information to the committee.
- vi. The Program Review Committee (including a representative from the Human Rights Committee) makes a recommendation to the Regional or Training School Director for final approval or disapproval, as outlined in PRC and HRC Procedures.
- vii. The Regional or Training School Director gives approval, approval with qualifications, or disapproval to the plan after considering the recommendations of the Program Review Committee.

If the Regional or Training School Director decides to approve a plan despite the Program Review Committee or Human Rights Committee recommendation for disapproval, the reason for the approval along with the plan and the committees' recommendations shall be sent to the commissioner. The commissioner must concur with the plan approval before it may be implemented.
- viii. A copy of the approved plan along with all reviews and signatures will be placed in the individual's file.
- ix. Staff with appropriate training/in-service and experience will be assigned to implement the plan.
- x. When an individual is restrained by physical or mechanical restraint techniques, on either an emergency or planned basis, the staff applying the restraint shall complete a DDS "Incident Report Form" (i.e., DDS form #255) and send the form to the parties designated on the form. (See I.D. PR 009 Incident Reporting)

- b. When an individual moves to a new community living arrangement or from one region to another, the planning and support team shall convene to develop an overall plan of services within 30 days. If the planning and support team decides to continue use of aversive procedures that were previously approved under procedures described in this policy, such plans shall be scheduled for review by the new region's Program Review and Human Rights Committees. Such plans may continue to be used at previously approved levels while awaiting Regional review. Recommendations for increased use of aversive procedures must be reviewed prior to implementation.
3. Required Documentation For Aversive Procedures
- Documentation shall include all information listed in Section E-2-a above, and in the Program Review Committee Procedure I.E. PR 004. Review all required documentation listed in these two references. Some, but not all, of the required elements that need to be documented include:
- a. A statement from a physician that the proposed aversive procedure is not medically contraindicated.
 - b. Methods for increasing positive behaviors and decreasing undesirable behaviors.
 - c. Objective and specific definitions of all salient target behaviors.
 - d. Methods for measuring the undesirable behaviors to be reduced and positive behaviors to be learned or increased. Data must be presented on all identified behaviors.
 - e. Consequences for the undesirable behaviors.
 - f. Criteria for insuring that the least restrictive level of aversive intervention is employed.
 - g. A plan for reducing or eliminating the use of the aversive procedure.
 - h. The circumstances under which the aversive procedure will be used, and a procedure for supervising implementation of the intervention.
4. Emergency Use Of Physical Restraint, Mechanical Restraint, Or Behavioral Modifying Medication.
- a. Once all available non-aversive measures have been attempted and client behaviors continue to pose a health/safety risk to self or others, emergency use of Commissioner-approved physical &/or mechanical restraint and /or chemical restraint may be necessary.
 - b. All providers shall establish general written procedures to be followed in emergencies. These procedures shall designate supervisory or professional staff who may authorize emergency procedures and the Commissioner-approved techniques or devices may be used.
 - c. Each use of physical, mechanical, & chemical restraint will be immediately reported using the DDS Incident Report form #255 and entered in CAMRIS. The incident will be monitored by the Regional PRC & HRC. I.R. form #255 documentation of use of aversive procedures shall be included in the individual's record.
 - d. When physical, mechanical, &/or chemical restraint is used as an emergency intervention, supervisory or professional staff shall examine the client within 24 hours and report any evidence of trauma to the nurse or physician and to the Regional or Training School Director.(including a DDS I.R. form #255 report).
 - e. Within three working days of an emergency incident, the planning and support team, including the physician, shall review the client and his or her environment to determine if changes in the plan including continued use of emergency aversive procedures are

required. This review does not have to be a physical meeting; it can be an electronic or phone 'meeting'. However, in all cases, it must be documented.

- f. If the PST plans to continue to employ the emergency aversive procedure, or if data indicates an ongoing pattern of use (i.e., once per month for three months or three times within a 30-day period), a behavior support plan shall be designed and the approval process started within five days of the planning and support team meeting.
5. Emergency procedures involving police and/or hospitalization
- a. When a person is experiencing acute behavioral/psychiatric symptoms that constitute a crisis and may lead to the need for an in-patient level of care, the program manager or senior on-duty staff person shall assess the situation to determine that all appropriate programmatic interventions have been exhausted prior to accessing outside emergency resources, that is, police and/or ambulance transport to a hospital.
 - b. Where possible, a psychologist or behavior management specialist shall assess the behavior and the effectiveness of programmatic interventions to determine if outside emergency measures are warranted.
 - i. When assessment determines that there is an imminent risk such that the person is a danger to themselves or others, 911 will be called by staff to obtain outside emergency services (police and/or ambulance transport).
 - (a) Immediately following the involvement of emergency services, agency staff shall call the Regional Director or their representative and notified about the use of emergency services.
 - ii. If there is not an imminent risk to that person or others, but the mechanisms in place are not adequate to assess the issues associated with the level of risk involved, the Mobile Outreach Crisis Team or other available crisis team (i.e. the agencies own Crisis Team) should be called, within 2 working days, by supervisory or psychology staff to assess the problem.
 - iii. When a person is experiencing acute behavioral/psychiatric symptoms that exceed the ability of a group home, family home or other type of living situation, and that person has been brought to an emergency room for evaluation, the following procedures apply:
 - (a) During a normal work day, the residential manager / team manager , or private agency management / clinical staff will be called and will be apprised of the situation and need for emergency room intervention. For evenings, weekends and holidays, the Regional Manager-On-Call system will be employed.
 - (b) When possible, the treating psychiatrist, psychologist or behaviorist will be notified of the situation and be asked to consult directly with the emergency room physician or psychiatric clinician on duty.
 - (c) Once evaluated, if a hospital level of care is not necessary, the treatment team will give consideration to other community-based supports and services with assistance from Department of Mental Health and Addiction Services (DMHAS) Local Mental Health Authorities (LMHAs) when possible.
 - (d) For those requiring a hospital level of care who are accepted to a private hospital for treatment, notify the DDS Regional Director or his/her designee that such hospitalization has occurred.

- (e) If someone is admitted to either a private psychiatric hospital unit or to a public DMHAS facility, the PST shall assure that a psychiatric admissions form is filled out, sent to the appropriate regional staff, and forwarded to the Deputy Commissioner's Office or her designee at Central Office.
- c. In either emergency hospitalization or police intervention situations, the PST, including the parent, guardian or advocate, shall convene within 5 working days to assess the following factors that may have contributed to the problem.
 - i. Recent situational factors in the person's residence, workplace or community
 - ii. Environmental issues, such as friction with roommates, coworkers or family members
 - iii. Medical conditions that may be causing pain or discomfort
 - iv. Whether programmatic interventions have been exhaustive and unsuccessful
 - v. Additional interventions, such as staff or behavioral consultation, have been considered
 - vi. A change in the place of the person's living arrangement
- d. Following the assessment, the team shall develop a plan to address the situational, environmental and behavioral issues that caused the emergency. The Program Review and Human Rights Committee will be notified of the emergency.

F. References

1. Statutes
 - a. CT General Statute 17a-210
 - b. CT General Statute 17a-238
 - c. CT General Statute 45a-677
 - d. CT General Statute 45a-677(e)
 - e. CT General Statute 46a-11 et seq.
2. Rules, Regulations and Policy –
 - a. ICF/MR Federal Regulations – 42 CFR Part 483 Subpart D 483-420, “Condition of Participation, Client Protections”
 - b. ICF/MR Federal Regulations – 42 CFR Part 483 Subpart D 483-440, “Condition of Participation, Active Treatment Services”
 - c. ICF/MR Federal Regulations – 42 CFR Part 483 Subpart D 483-450, “Condition of Participation, Client Behavior and Facility Practices”
3. Rules, Regulations and Policy or Instructions – DMR
 - a. Department of Developmental Services Regulations - Sections 17a-238-7 through 17a-238-11.
 - b. DDS I.F.PO.001, Abuse and Neglect Prevention
 - c. DDS I.F.PR.001, Abuse and Neglect Prevention, Reporting, Notification, Investigation, Resolution and Follow-up

- d. DDS I.E.PR.002, Behavior Support Plans
- e. DDS I.E.PR.003, Behavior Modifying Medications
- f. DDS I.E.PR.004, Program Review Committee
- g. DDS I.C.PR.001 through 004, Case Manage Procedures
- h. DDS I.E.PR.006, Pre-sedation for Medical/Dental Procedures
- i. DDS, II.G.PO.001, Office of the Commissioner Institutional Review Board (IRB)
- j. DDS.II.G.PR.001, Office of the Commissioner Institutional Review Board (IRB)
- k. DDS I.F.PR.006, Human Rights Committee
- l. DDS Policy 7, Programmatic Administrative Review
- m. DDS Policy 13, Advocates