## **Procedure No:** I.E.PR.004 **Issue Date:** October 22, 2003

## **Subject: DDS Program Review Committees** **Effective Date:** Upon Release

# **Section:** Health and Safety **Revised Dates:** 2009, 2018

##  **Revised Date:** August 1, 2022

#  **Approved:**/s/Jordan A. Scheff/LT

**Policy Statement**

To achieve the best outcomes for individuals who have behavioral health needs coupled with intellectual disability, DDS encourages the use of positive behavior supports embedded in an individual’s comprehensive behavior support plan. An individual’s behavior support plan is a tool by which DDS can monitor and track various aspects of behavioral supports including the use of behavior modifying medications, psychiatric medications, planned restraints and aversive procedures to determine what combination is likely to achieve the best results for the individual. To make sure that each behavior support plan and the use of psychotropic and other behavior modifying medications remain appropriate to each individual’s circumstances, DDS created regional Program Review Committees to examine and assess behavior support plans and recommend changes when necessary.

The goals of DDS’s Program Review Committees are to (1) reduce the overuse of behavior modifying medications through reviews and recommendations, (2) provide consultation and feedback to clinicians and behaviorists in a supportive environment, and (3) promote the use of positive behavior supports for individuals with intellectual disability and other developmental disabilities.

# **Purpose**

 This procedure delineates the process through which the regional DDS Program Review Committees review the use of psychotropic and other behavior modifying medications and behavior support plans for individuals eligible for or receiving funding or services from the Department of Developmental Services.

# **Applicability**

This procedure applies to individuals with annualized funding from DDS and who (1) receive Behavior Support Services as part of a DDS Medicaid Waiver; or (2) have a planned restraints or seclusion protocol. This procedure also applies to any individual who is administered behavior modifying medication and receives services in or from a DDS-operated, funded or licensed residential facility, including Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Community Living Arrangements (CLA), Continuous Residential Services (CRS) homes, and Community Companion Homes (CCH).

For those individuals with annualized funding from DDS who do not live in a DDS-operated, funded or licensed residential facility, use of behavior modifying medications prescribed by a prescribing practitioner may be initiated upon consent of the individual, guardian or legal representative, or if the individual does not have the capacity to consent and has no guardian or legal representative, with the approval by an emergency Program Review Committee review, pending a full review by the regional Program Review Committee and regional Human Rights Committee, if applicable. An individual who lives on their own or with their family may request a voluntary PRC review if there are concerns about the individual’s medications or behavior supports.

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

This procedure also applies to all DDS employees and to all DDS qualified provider employees.

1. Definitions

"Aversive procedure” means the contingent use of an event or a device which may be unpleasant, noxious, or otherwise cause discomfort for an individual to (A) alter the occurrence of a specific behavior, or (B) protect the individual from harming himself or herself or another person. Aversive procedures may include the use of physical isolation, mechanical restraint, physical restraint, chemical restraint, or other department approved methods used to control or change behaviors of concern that pose a risk to the individual or other persons in accordance with sections 17a-238-7 to 17a-238-13, inclusive, of the Regulations of Connecticut State Agencies.

"Behavior modifying medication” means any chemical agent used for the direct effect it exerts upon the central nervous system to modify thoughts, feelings, mental activities, mood, or performance. These chemical agents or psychiatric medications include, but are not limited to, antipsychotics or neuroleptics; antidepressants; anti-anxiety agents; stimulants; and sedatives or hypnotics. Other medications that are not typically described as psychiatric medications such as certain anticonvulsants, beta-blockers and other drugs, if they are prescribed primarily for their psychiatric effects, such as mood stabilization and impulse control, are covered by this definition**.**

“Behaviorist” means a person qualified by DDS with specialized training and experience in authoring and implementing behavior support plans.

“Behavior support plan” means a written document developed to address an individual’s behaviors of concern which interfere with the implementation of the goals and objectives identified in the individual plan or to monitor target behaviors, both positive and negative ones. The plan shall include identification of the specific behaviors of concern to be addressed, positive replacement (i.e., functionally equivalent) behaviors to be substituted, and a plan for monitoring an individual’s adaptive and maladaptive responses. The approach selected for development of a behavior support plan (i.e., Positive Behavior Support or Applied Behavior Analysis) should be selected based on the best practices that have been recognized for an individual’s presenting problems, existing diagnoses, and treatment recommendations.

“CAMRIS” means the Department of Developmental Service’s management information system.

“Chemical restraint” means psychiatric medication administrated on an emergency basis to an individual, who is in danger of harming himself or herself or another person, when all other interventions have failed. Medications used for pre-sedation for medical or dental procedures are not considered to be chemical restraints.

“Commissioner” means the Commissioner of the Department of Developmental Services.

“Functional Behavior Assessment” or “FBA” means an individual-specific, information-gathering process conducted by a behaviorist as an integral part of developing and maintaining a behavior support plan. It allows for ongoing revisions to the behavior support plan and relies on data-driven decision-making. An FBA includes the following key steps: (1) identifies and describes problem behaviors through direct observation and data collection; (2) identifies and describes antecedents and consequences (i.e., environmental factors) that precipitate and maintain the problem behaviors; (3) develops hypotheses about the functions or purposes of the challenging behaviors (e.g., communication, modulation of internal distress, sensory stimulation, access to tangibles, and social-environmental control); and (4) creates interventions to develop adaptive (i.e., replacement) behaviors that serve to help eliminate challenging behaviors. Note that a Functional Behavior Assessment is different than a Functional Analysis (i.e., an empirical method of determining variables that give rise to a problem behavior).

"Human Rights Committee" or “HRC” means a group of persons in each DDS region and at the Southbury Training School, who are not employees of the department, who provide monitoring to ensure the protection of legal and human rights of persons with intellectual disability and other developmental disabilities. Membership of a regional HRC may include a physician, an attorney, a parent or guardian, staff of qualified provider agencies, and other volunteers. The HRC shall act as an advisory group to the regional or training school director. A DDS employee shall act as a liaison between the HRC and a region or the training school.

"Individual" means a person who is receiving funding or services from the Department of Developmental Services.

“Intra-class polypharmacy” means the use of two or more medications from the same class of medication (e.g., use of two neuroleptics, the use of two antidepressants, the use of two antianxiety agents, etc.)

“Mechanical restraint” means an apparatus used to restrict an individual’s movement, including any device, such as helmets, mitts or bedrails, used to prevent self-injury. Devices designed by a physical therapist and approved by a physician that are used to achieve proper body alignment or balance, and protective devices approved by a physician to address an individual’s medical condition are not mechanical restraints.

“Physical isolation” means an aversive procedure whereby an individual is separated from others, usually by placement in a room or area alone.

"Physical restraint" means a department-approved physical intervention used to restrict an individual’s movement to protect the individual or to prevent self-injury or injury to another person.

“Planning and support team” or “PST” means the group that includes the individual; the individual’s legal representative, if any, family members or chosen advocates, as applicable; the individual’s case manager; a registered nurse; persons who provide supports and services to the individual; and any other person who the individual requests to participate. The planning and support team shall assist the individual to develop, implement, and evaluate his or her individual plan and shall assist the individual to obtain, manage, evaluate, and adjust supports, as needed.

“PRC contact” means the person who fills out, completes and submits a Request for PRC Date (I.E.PR.004 Attachment A Request for PRC Date to Review Behavior Modifying Medication or Aversive or Restraint Procedures) to the regional Program Review Committee. The PRC contact may be a member of the individual’s planning and support team (PST) or an employee of the individual’s DDS qualified provider.

“PRC liaison” means the DDS employee selected by the regional or training school director to act as the liaison between the PRC and the director, the department’s central office, and all qualified providers.

“Prescribing practitioner” means a physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse or nurse-midwife licensed by the state of Connecticut and authorized to prescribe medication within the scope of such person's practice. The prescribing practitioner preferably should have experience in treating individuals with intellectual disability or other developmental disabilities.

"Program Review Committee" or “PRC” means the group in each DDS region and at the Southbury Training School, which includes a psychiatrist or advanced practice registered nurse (APRN), a psychologist, an educational specialist and DDS professional staff, that reviews an individual’s behavior support plan and an individual’s behavior modifying medications to ensure that the plan is clinically sound and supported by appropriate documentation and that any medications prescribed are being administered in conformance with sections 17a-210-1 to 17a-210-10, inclusive, of the Regulations of Connecticut State Agencies and DDS policies, procedures and directives. The PRC acts as an advisory group to the regional and training school directors.

“Restrictive intervention” means any intervention that prevents the individual from having access to specific categories of objects that are likely to be dangerous for the individual or others. Restrictions may apply to knives, sharp objects, cleaning fluids, matches, lighters, or other objects that could cause harm or be used as a weapon. Restrictions also may apply to behaviors, which are considered unsafe, or harmful (e.g., smoking, food choice or consumption). Restrictions may be imposed through the use of locks on doors, cabinets or closets.

1. **Implementation**
2. Program Review Committee (PRC) Guiding Principles
3. A Program Review Committee (PRC) presentation is done on behalf of an individual, if the following criteria is met:
	1. The first time an individual’s behavior support plan is presented to PRC after the individual has been prescribed any behavior modifying medication.
	2. A paper review of a behavior support plan that results in a PRC referral for presentation.
	3. The use of intra-class polypharmacy of antipsychotics, (i.e., the use of two or more antipsychotic medications).

* 1. Any planned use, modified use, or application of planned floor control.

**Note:** “Prone” or “Face Down” restraint is strictly prohibited.
**Note:** A planning and support team (PST) review is required when (1) emergency restraints have been used three or more times within a 30-day period; or (2) there is a pattern of emergency restraints (e.g., one restraint per month for three consecutive months). The PST may determine whether planned restraints are needed or whether the cause for restraints can be alleviated through alternative means that do not require regular use of restraints.

* 1. Identified concerns with the individual’s behavior support plan (i.e., inadequate functional assessment, overly reactive strategies).
	2. Initial use or modification of the use of an aversive procedure (i.e., the contingent use of an event or device which may be unpleasant, noxious, or otherwise cause discomfort).
1. A Program Review Committee (PRC) Paper Review is conducted, if the individual’s behavior support plan meets one of the following criteria:
2. The use of behavior modifying medications, which do not include medications for pre-sedation, herbal treatments, fish oil, melatonin, Cogentin, Artane, etc.
3. No use of intra-class polypharmacy.
4. No use of planned floor control.
5. When a new or different behavior modifying medication is prescribed for the individual.

c. The need for a PRC review, the type and extent of the review, and the length of the review cycle is determined by the regional Program Review Committee and is based on individual circumstances. Any future PRC reviews shall be determined by the regional PRC.

d. Medications that do not require a PRC review include:

1. Medications for neuromuscular and neurodegenerative disorders that are used solely for the treatment of conditions such as Cerebral Palsy, Amyotrophic Lateral Sclerosis (ALS), Muscular Dystrophy, or Multiple Sclerosis;
2. End-of-life medications that are not being used for behavior modifying purposes;
3. Medications intended to improve memory loss resulting from dementia;
4. Benadryl or its generic equivalents;
5. Melatonin as a sleep aid prescribed and used in accordance with DDS Health Standard 18-1; and
6. Herbal medications prescribed and used in accordance with DDS Health Standard 18-1.
7. Physical interventions, either emergency or planned, are only an appropriate response in circumstances where an individual poses a significant risk of harm to himself or herself, or to others. Physical restraints are never to be used to discipline, punish, demonstrate authority, or enforce compliance.
8. To maintain the individual’s health and safety, the planning and support team should identify the individual’s vulnerabilities and determine potential risk factors associated with the use of physical restraints. The individual’s planning and support team should be encouraged to seek the use of nonphysical strategies (e.g., de-escalation) to reduce the use of physical restraints.
9. The individual’s planning and support team and any other staff or caregivers shall ensure that, if physical restraints are to be used, these restraints are applied using best practices to help prevent adverse physiological and psychological outcomes for the individual. Only staff with department-approved training shall implement physical restraints. Physical restraint best practices are as follows:
10. The use of physical restraints may be contraindicated because of an individual’s medical history, anatomical features, or current illnesses (e.g., asthma, seizure disorder, obesity), psychological challenges (e.g., psychotic states, history of posttraumatic stress), and situational or environmental factors (e.g., hot humid environment, alcohol or drug use);
11. The individual’s safety and welfare should be continuously monitored by staff for signs of distress (e.g., difficulty breathing, discoloration, vomiting, reduced consciousness, inability to communicate, awkward body position, increased body temperature, and complaints of pain). Staff are required to discontinue physical restraints immediately upon any evidence of these types of difficulties;
12. Any physical interventions by staff are required to be the least restrictive measures possible and only maintained for the shortest period of time possible as prolonged restraint (i.e., duration longer than 10 minutes) heightens the risk of adverse consequences; and
13. Any use of physical restraint by staff should be followed by a debriefing process wherein the individual may express any complaints of discomfort he or she experienced, and the individual’s planning and support team may conduct a risk-to-benefit assessment of the restraint episode.
14. The individual’s planning and support team is required to thoroughly investigate the individual’s medical, environmental, and emotional issues that may influence or contribute to a behavior of concern before considering a trial prescription of a psychotropic or other behavior modifying medication. Mental health or psychiatric difficulties may not be easily recognized in the context of developmental disabilities and may be falsely attributed to the individual’s intellectual disability (i.e., diagnostic overshadowing bias).
15. Valid reasons to prescribe psychotropics may include, but are not limited to, (1) the presence of risk of harm to self or others; (2) the treatment of a clearly diagnosed psychiatric disorder; (3) the treatment of medical conditions with secondary psychiatric features; (4) the failure of non-psychotropic-based interventions (e.g., when a high intensity and frequency challenging behavior is resistant to environmental interventions and continues to interfere with functioning); (5) the need to stabilize an individual in order to implement non-medication-based interventions; or (6) favorable past treatment response to psychotropics.
16. Questionable uses of psychotropics include, but are not limited to, if (1) there is no re-examination of the original rationale for the use of psychotropics; (2) there is a lack of evidence of the benefits of continued usage; (3) psychotropics are used to treat life events that have been pathologized (e.g., trauma, grief); or (4) psychotropics are being used as a substitute for appropriate supports.
17. The individual’s planning and support team is required to monitor for concerns about the use of psychotropics by the individual in the following areas: (1) higher than recommended dosages; (2) excessive reliance on psychotropic medication; (3) lack of compelling evidence to support the medication’s effectiveness; (4) use of medication without informed consent; and (5) use of medication for symptomatic treatment versus understanding the etiology of the individual’s condition.
18. An individual’s planning and support team that is seeking a psychiatric consultation shall identify three or four of the individual’s specific symptoms and behaviors (e.g., insomnia, low motivation) to target, in order to help reduce the risk of polypharmacy.
19. A designated professional staff person (e.g., case manager, nurse, psychologist, social worker) shall obtain informed consent from the individual and the individual’s legal representative, if any, for the (1) prescribing of psychotropics or other behavior modifying medications to the individual; (2) introduction or continuation of an aversive program; or (3) use of pre-sedation medication. The designated professional staff person shall complete the Program Review Committee Consent for Treatment form (I.E.PR.004 Attachment C PRC Consent for Treatment) and return it to the individual’s case manager who shall share it with the individual’s planning and support team for inclusion in the individual’s PRC packet.

When a designated professional staff person seeks to obtain informed consent for the prescribing of psychotropics or other behavior modifying medications to an individual, key discussion points should include, but are not be limited to, (1) that these medications are not dispensed without a thorough evaluation of the individual and his or her medical history; (2) discussion of the specific condition to be treated; (3) any alternatives to medication that are being considered; and (4) identifying the risks, benefits, safeguards, proper administration, and tapering plan associated with each psychotropic or behavior modifying medication.

1. The ways in which psychotropics are metabolized tend to vary based on individual factors (e.g., age, gender, race, ethnicity, physical condition). Therefore, in certain complex cases, an individual’s planning and support team may recommend genetic enzyme testing (i.e., pharmacogenomics for psychotropic medications) to narrow the operational parameters of prescribing the most appropriate psychotropic or behavior modifying medication. It is important to understand that when metabolism is reduced, high blood levels of a medication may cause negative side effects. Conversely, when metabolism is rapid, lower blood levels of a medication may result in poor therapeutic benefits. It is important for staff and caregivers to recognize that genetic variations may lead to neurotransmitter imbalances and other adverse reactions (e.g., dysfunction in the serotonin receptor gene 5HT2C which relates to weight gain when using atypical antipsychotic medications and recommendations for implementation of anti-obesity interventions).
2. In evaluating an individual’s ongoing use of psychotropic and other behavior modifying medications, the planning and support team is required to follow a de-prescribing protocol, when possible, that includes (1) a record of all the medications the individual is currently taking and the reasons for taking each medication; (2) considering the current and future benefit compared to the potential harm in the use of each medication; and (3) prioritizing medications for discontinuance, starting with those medications that have the least benefit and the lowest adverse withdrawal reactions.
3. The individual’s planning and support team is required to document and respond as soon as possible to the emergence of self-injurious behaviors especially in cases of self-injury to the head. If indicated, addition of the target behavior of self-injury to the head (i.e., head hitting) shall be incorporated into the individual’s behavior support plan. The handling of self-injury to the head shall be consistent with the March 19, 2009 DDS memo “Implementation of OPA Recommendations Regarding Supporting People Who Have Self-Injurious Behavior” (I.E.PR.004 Attachment G DDS Memo Concerning OPA Recommendations for Self-Injurious Behavior). The memo details requirements for head hitting including, but not limited to, that the behaviors are clearly defined, documented in terms of both intensity and frequency, emergent head injury is documented appropriately, protective interventions are used as indicated, and medical emergent needs are monitored and relayed for follow-up and intervention.
4. **Program Review Committee Membership and Charge**
5. Each DDS region and the Southbury Training School shall have a Program Review Committee (PRC) appointed by the regional or training school director. The regional PRC shall act as an advisory group to the regional or training school director.
6. The membership of a regional PRC shall include a regional PRC liaison, a licensed psychiatrist or a licensed APRN, and a psychologist with experience in intellectual disability and other developmental disabilities. PRC membership may also include other appropriate DDS managers or staff, DDS Human Right Committee (HRC) representatives, or clinicians from relevant disciplines.
7. The regional PRC shall review, make recommendations, and approve the use of:
8. Behavior modifying medications submitted for review for clinical appropriateness, including (1) new medications, or (2) any change to previously approved medications or their dosage ranges;
9. Any behavioral support plan for an individual who is prescribed behavior modifying medications;
10. Any behavior support plan that contains the use of an aversive procedure, including (1) new behavioral strategies, or (2) changes to previously approved behavior support plans, if they include an aversive procedure;
11. Any intervention or measure used with an individual that is a best practice, such as mood assessment, suicide or crisis protocol, or head injury guidelines (See I.E.PR.004 Attachment G DDS Memo Concerning OPA Recommendations for Self-Injurious Behavior to properly address head injury severity levels); and

1. A planned restraint procedure agreed upon by the individual’s planning and support team.
2. The case manager, a designated professional member of the individual’s planning and support team, or a PRC contact shall send a request for PRC review using the DDS Request for PRC to Reviewform (I.E.PR.004 Attachment A Request for PRC Date to Review Behavior Modifying Medication or Aversive or Restraint Procedures) when an individual has:
	1. An order for a new behavior modifying medication;
	2. An order for a change in the medication dosage that exceeds the current FDA-approved range; or
	3. A newly-developed behavior support plan with an aversive procedure (i.e., the contingent use of an event or device which may be unpleasant, noxious, or otherwise cause discomfort) or a restraint procedure.

1. A designated professional member of the individual’s planning and support team shall submit by email the PRC packet required by the regional PRC to the regional PRC liaison at the designated regional PRC email address within the specified time frame using the DDS Program Review Committee face sheet (I.E.PR004 Attachment B PRC Face Sheet). The packet shall contain documentation of:
	1. The completed DDS Program Review Committee form (I.E.PR.004 Attachment B PRC Face Sheet);
	2. Behavior support plan with a “Functional Behavior Assessment” or “FBA” which is the systematic assessment of an individual’s behavior that yields: (1) an operational description of the behaviors of concern; (2) the ability to predict the times and situations in which the behaviors of concern are most and least likely to occur across the full range of typical daily routines and settings; (3) a description of the function or purpose that the behaviors of concern serve for the individual; (4) an understanding of the medical, environmental, interpersonal, and other ecological factors that shall be considered in the development of an effective programmatic response to the behaviors; and (5) identification of positive replacement behaviors, and treatment goals;
	3. Behavioral data and graphs;
	4. The three most recent Psychiatry or Prescriber Notes;

* 1. The individual’s behavior modifying medication history;
	2. Response to most recent PRC requirements and suggestions;
	3. List of other medications prescribed to the individual;
	4. The most current assessment for “extrapyramidal side effects” or “EPS” including Tardive Dyskinesia completed within the previous six months for individuals taking antipsychotic medications, if applicable;
	5. Laboratory results of blood tests when behavior modifying medication ranges are evaluated through blood levels;
	6. The individual’s medication plan or plans (I.E.PR.004 Attachment F PRC Medication Prescriber's Treatment Plan) if not already detailed and outlined in the psychiatric prescriber notes or consultation forms; and
	7. The individual’s PRC Consent for Treatment form (I.E.PR.004 Attachment C PRC Consent for Treatment).
1. The PRC review shall determine if an individual’s behavior support plan has been developed using the best standards of practice. These best practices include (1) treating the individual in a respectful, age-appropriate manner; (2) incorporating the standards into the individual’s daily routine; and (3) having the best practice standards being used in a natural context. The individual, the individual’s legal representative, if any, family members, chosen advocates, and support staff shall be involved in the design of his or her positive behavior supports, when clinically appropriate.

g. The PRC may make recommendations regarding the approval of all behavior support plans including proposing the use of a range of aversive procedures from the least to the most restrictive, with specific criteria for each restriction.

h. The individual, the individual’s legal representative, if any, family members, or chosen advocates may attend the program review committee meeting for the purpose of hearing the presentation and presenting any supporting or opposing views to the committee.

i. The regional PRC shall refer cases for a full Human Rights Committee (HRC) review, if the PRC has a concern on a treatment approach that uses aversive or restraint procedures.

# **Required follow-up after any Program Review Committee Review**

a. The regional PRC shall document its recommendation to:

i. Approve the individual’s behavior support plan or plans, or functional behavioral assessment, or both; or

ii. Provisionally approve the individual’s behavior support plan with qualifications and specify:

I. PRC’s qualifications for the plan to be approved; and

II. Requirements to address and satisfy the PRC’s qualifications within 90 days; or

iii. Disapprove the individual’s behavior support plan or functional behavior assessment, or both. If disapproved, the individual’s planning and support team shall address the PRC’s concerns that led to the disapproval as soon as possible.

1. A Psychiatric Medication Review shall be completed by the prescribing practitioner (e.g., psychiatrist, APRN) within the scope of the prescriber’s practice in conjunction with other regional PRC members. The PRC’s Psychiatric Medication Review shall:
2. Approve the individual’s psychiatric medication plan; or
3. Provisionally approve the individual’s psychiatric medication plan with qualifications and specify:
4. PRC’s qualifications for the psychiatric medication plan to be approved; and

II. Requirements to address and satisfy the PRC’s qualifications within 90 days; or

1. Disapprove the individual’s psychiatric medication plan. If disapproved, the individual’s planning and support team shall address the PRC’s concerns that led to the disapproval as soon as possible.
2. The regional PRC shall document the time frame for the next PRC review of the individual’s behavior support plan or psychiatric medication plan. Interim changes to an individual’s behavior support plan or psychiatric medication plan shall be reviewed at the next scheduled regional PRC meeting. The effectiveness of any changes to the psychiatric medication plan or behavior support plan shall be documented clearly in the PRC packet submitted.
3. The regional PRC may recommend a full review of an individual’s behavior support plan by the regional Human Rights Committee (HRC). If a full HRC review is recommended, the individual’s planning and support team shall submit a request for HRC review with the completed HRC packet to the regional HRC liaison if the continued use of aversive procedures is part of the individual’s plan.
4. The PRC shall forward its feedback and recommendations regarding its most recent review of the individual’s plan or plans to the regional or training school director or the director’s designee for their review and approval.
5. Information and data concerning the individual provided during PRC reviews shall include (1) psychiatric medications; (2) behavior support plans; (3) screenings for tardive dyskinesia (irregular movements of the mouth and face); (4) monitoring for “extrapyramidal side effects” or “EPS” that are abnormal movements of voluntary or involuntary muscles induced by antipsychotic medications, which may include characteristic EPS symptoms such as dystonia (muscle contractions or spasms), dyskinesia(Parkinson-like movements such as rigidity and tremors), or akathisia (motor restlessness in the extremities); and (5) dates of PRC reviews of the individual’s behavior support plan or psychiatric medication plan which are maintained in CAMRIS by the regional PRC liaison or his or her designee.
6. For individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), the regional PRC or the ICF/IID’s internal PRC shall review the use of behavior modifying medication prescribed as pre-sedation for medical or dental appointments or procedures and shall review documentation for evidence that behavior support strategies have been offered as an alternative intervention when the potential for the overuse of sedatives by the individual exists.
7. For individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), the DDS qualified provider may seek interim approval for the use of behavior modifying medication by submitting a completed Request for Program Review Committee Interim Approval form to the regional PRC liaison (I.E.PR.004 Attachment D ICF/IID Request for PRC Interim Approval). If an interim approval is granted, the regional PRC shall review the interim approval and the individual’s PRC packet at the next regularly scheduled review of the individual’s plan or plans. The regional PRC’s full review of the use of behavior modifying medication shall render a decision on the approval or disapproval of the use of behavior modifying medications for this purpose.
8. **Exemption from Program Review Committee Review**
9. An exemption from a PRC review may be requested by an individual who wishes, and has the capacity, to independently make decisions about the use of psychiatric medications that would otherwise require PRC review.
10. An individual may request to be exempt from PRC review if the following criteria applies:
11. The individual takes behavior modifying medications and has a behavior support plan that does not include aversive or restraint procedures; and
12. The individual lives independently, manages his or her own health care, and is capable, with supports, of making medical decisions.
13. Exemption from a PRC review also may be based on the type and level of the individual’s supports, specifically how the individual is able to manage his or her medical care which may include community resources such as visiting nurse services.
14. If the individual has a guardian or other legal representative, the individual may be exempt if he or she meets the exemption criteria and the guardian or other legal representative agrees to the exemption.
15. If an individual meets the exemption criteria and does not have a guardian or other legal representative, then the individual’s planning and support team (PST) and the region’s PRC Exemption Committee shall approve or disapprove the individual’s PRC exemption.
16. An individual who meets the PRC review exemption criteria may request to be exempt by completing the PRC exemption process as follows:
17. The individual or his or her guardian or other legal representative shall complete, with the individual’s case manager’s assistance, a Request to be Exemptfrom the PRC Review Process (See I.E.PR.004 Attachment E Request for Exemption from the PRC Review Process) and detailing the individual’s:
18. Guardian’s or legal representative’s status;
19. Current living situation;
20. Medical appointment status;
21. Current medications; and
22. Types of natural and community supports.
23. The individual’s planning and support team (PST) shall document any additional pertinent information and shall include a statement as to whether the PST members concur or disagree with the individual’s request for exemption from PRC review. These PST documents shall be attached to the Request to be Exempt from the PRC ReviewProcessform.
24. The individual’s case manager shall submit the completed Request to be Exempt from the PRC ReviewProcess form to the regional director, or the director’s designee, for review by the region’s PRC Exemption Committee.
25. The region’s PRC Exemption Committee shall approve or disapprove the individual’s request and document the committee’s decision on the form.
26. The region’s PRC Exemption Committee shall retain a copy of the PRC exemption form and forward the original document to the individual’s case manager.
27. The individual’s case manager shall file the original Request to be Exempt from the PRC ReviewProcess form in the individual’s file and send a copy of the form to the region’s PRC liaison.
28. If the individual’s exemption request is approved, the decision shall be documented in CAMRIS by the regional PRC coordinator, or the coordinator’s designee.
29. The individual’s case manager shall review the PRC review exemption not less than annually, or more frequently if indicated by changes in the individual’s health or cognitive status. The case manager shall document whether the exemption from PRC review remains appropriate during the individual’s annual planning meeting. If the individual’s exemption status remains appropriate, the case manager shall document and date such status on the original Request to be Exempt from the PRC ReviewProcess form. If the PRC review exemption status is determined not to be appropriate, the individual’s case manager shall notify the region’s PRC liaison and the region’s PRC Exemption Committee chairperson.
30. **References**

**Federal**

ICF/IID Federal Regulations 483-420, “Condition of Participation, Client Protections”

ICF/IID Federal Regulations 483-440, “Condition of Participation, Active Treatment Services”

ICF/IID Federal Regulations 483-450, “Condition of Participation, Client Behavior and Facility Practices”

**Connecticut General Statutes and Regulations of Connecticut State Agencies**

Section 17a-210 “Department and Commissioner of Developmental Services. Duties. Patient transfer, programs and placement. Right to object and hearing” of the Connecticut General Statutes

Section 17a-238 “Rights of persons under supervision of Commissioner of Developmental Services” of the Connecticut General Statutes

Section 45a-677, et seq. “Connecticut Uniform Adult Protective Proceedings Jurisdiction Act” of the Connecticut General Statutes

Section 46a-11a, et seq. of the Connecticut General Statutes

Sections 17a-238-7 to 17a-238-13, inclusive “Aversive Procedures” of the Regulations of Connecticut State Agencies

**DDS Policy and Procedure**

DDS Case Management Policies and Procedures series

I.E.PR.006 Pre-sedation for Medical/Dental Procedures

I.F.PR.001 to I.F.PR.005 Abuse and Neglect Prevention Procedure series

I.F.PR.006 Human Rights Committee

I.F.PR.011 Programmatic Administrative Reviews

1. **Attachments**

I.E.PR.004 Attachment A [Request for PRC Date to Review Behavior Modifying Medication or Aversive or Restraint Procedures](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_A_Request_for_PRC_Date.docx)

I.E.PR.004 Attachment B [PRC Face Sheet](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_B_PRC_Face_Sheet.docx)

I.E.PR.004 Attachment C [PRC Consent for Treatment](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_C_PRC_Consent_for_Treatment.docx)

I.E.PR.004 Attachment D [ICF/IID Request for PRC Interim Approval](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_D_ICF-IID_Request_for_PRC_Interim_Approval.docx)

I.E.PR.004 Attachment E [Request for Exemption from the PRC Review Process](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_E_Request_for_Exemption_from_the_PRC_Review_Process.docx)

I.E.PR.004 Attachment F [PRC Medication Prescriber's Treatment Plan](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_F_PRC_Medication_Prescriber_Treatment_Plan.docx)

(Optional Form, used only if prescriber does not have his or her own Treatment Plan form)

I.E.PR.004 Attachment G [DDS Memo Concerning OPA Recommendations for Self-Injurious Behavior](https://portal.ct.gov/-/media/DDS/DDS_Manual/IE/IEPR004_Attachment_G_DDS_Memo_Concerning_OPA_Recommendations_for_Self-Injurious_Behavior.pdf)