## **Procedure No:** I.E.PR.003 **Issue Date:** October 22, 2003

## (Replaces I.E.P.R.002 Behavior Support Plans and **Effective Date:** Upon Release

# I.E.PR.003 Behavior Modifying Medications) **Revised Date:** October 1, 2009

## **Subject: Positive Behavior Support Program and**

## **Behavior Support Plans Revised Date:** February 1, 2018

# **Section:** Health and Safety **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 behavior supports including the use of behavior modifying medications, psychiatric medications, 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 remains appropriate to each individual’s circumstances, DDS created regional Program Review Committees to examine and assess behavior support plans and recommend changes when necessary.

# **Purpose**

The procedure details how behavior support plans are created and used to help individuals maintain healthy and appropriate behaviors and provide resources to deal with behavioral health challenges. It explains how positive behavior supports, behavior modifying medications and the appropriate use of aversive procedures are the foundation of these plans.

# **Applicability**

This procedure applies to all individuals receiving funding or services from DDS. This includes individuals receiving services in or from DDS-operated, funded, or licensed facilities, including Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Community Living Arrangements (CLA), Continuous Residential Services (CRS), Community Companion Homes (CCH), Employment Opportunities and Day Services, and DDS Individualized Home Supports (IHS). It applies to the planning and coordination of care for individuals residing in residential placements and those receiving individualized 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, or individuals who reside in long-term care facilities, residential care homes, or residential schools that are 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 another person. Aversive procedures may include the use of physical isolation, mechanical restraint, physical restraint, chemical restraint, or other department approved methods 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-manics; 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.

“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.

“Functional Behavior Assessment” or “FBA” means 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 is 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 serves 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 behavior; and (5) identification of positive replacement behaviors, and treatment goals.

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

“Institutional Review Board” or “IRB” means the group appointed by the Commissioner to review and approve activities categorized as research involving human subjects where the research is either conducted, supported, or otherwise subject to regulation by DDS. (See II.G.PO.001 and II.G.PR.001 Office of the Commissioner Institutional Review Board)

“Licensed prescriber” means a licensed physician (e.g., psychiatrist, neurologist, primary care physician) or APRN with experience in working with individuals with intellectual disability or other developmental disabilities.

“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 family, guardian or advocate, 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.

"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 behavioral 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.

1. **Implementation**

# **Components of a Positive Behavior Support Program**

1. A positive behavior support program avoids the use of coercion, punishment, spontaneous or planned ignoring of the individual and other adverse consequences in an attempt to control an individual’s behaviors of concern, as these behaviors may give rise to safety and ethical concerns for both the individual and his or her staff.
2. This avoidance of coercion, punishment and adverse consequences does not preclude the use of restrictions for an individual’s safety, (e.g., restricting a community outing at a time when an individual is unstable.)
3. This avoidance does not apply to those restrictions that are a natural consequence of the individual’s behavior, (e.g., an individual no longer has an electronic device that he or she has damaged.)
4. This avoidance also does not apply to restrictions imposed by the individual’s guardian when the guardian is directly involved, (e.g., permitting home visits.)
5. Coercive measures include (1) threats of restraint or seclusion, (2) removal of an individual’s rights and privileges, (3) response cost, and (4) forced apologies. Even minor forms of coercion may unintentionally produce negative effects on the individual. These effects may include (1) feelings of fear, frustration, and rejection, (2) engagement in retaliatory behaviors, (3) lowered self-esteem, and (4) reduced dignity.
6. The use of punishment-based measures has the potential to (1) heighten staff’s reactivity, (2) inadvertently create an overreliance on the external control of an individual, and (3) perpetuate the misconception that aversive procedures need to be continuously employed in order to avoid a return of behaviors of concern.
7. If the behavioral approach of spontaneous or planned ignoring of the individual is implemented or used, the individual shall be closely monitored for negative outcomes such as the worsening the individual’s emotional or behavioral functioning.
8. Any positive behavior support program designed to address an individual’s behaviors of concern requires a Functional Behavior Assessment (FBA) as a first step in developing a behavior support plan. FBA refers to information gathering on the individual’s behaviors of concern and determining the purpose that these behaviors serve for the individual. FBA lays the foundation for positive behavior support interventions for the individual.
9. An individual’s FBA includes identification of the antecedents and consequences of the individual’s behaviors of concern. It also includes a comprehensive understanding of the individual’s relevant biopsychosocial history and the factors that may have been crucial in the development and perpetuation of the behaviors. The individual’s FBA also may include a review of the individual’s medical conditions, neurological impairments, cognitive strengths and weaknesses, adaptive challenges, change in mental status, trauma history, psychosocial stresses, or family dynamics.
10. A completed FBA shall take into account the individual’s existing social and environmental circumstances as a precursor to the development of an effective behavioral support plan. The goal of any FBA is to identify the function or purpose of an individual’s behaviors of concern. With this information, staff can determine how to reduce the individual’s behaviors of concern by finding “functionally-equivalent” or “replacement” behaviors to help the individual meet his or her needs.
11. To develop an appropriate Functional Behavior Assessment (FBA) for an individual, a behaviorist shall:
    1. Identify the individual’s behaviors of concern that need to be decreased or eliminated in the following hierarchy:
12. Behaviors that threaten the health and safety of the individual or other persons, which includes a refusal of crucial medical care.
13. Behaviors that pose a barrier to the individual’s participation in services.
14. Inappropriate behaviors that hinder the individual’s adaptive and social functioning.
    1. Provide a clear description of how each of the individual’s behaviors of concern manifests including information about its frequency and rate, intensity, severity, and duration. The behaviors of concern need to be described in measurable and observable terms that are easily understandable.
    2. Address any events, vulnerabilities, or situations in the individual’s environment that trigger his or her behaviors of concern.
    3. Indicate the situations in which the individual’s behaviors of concern are most and least likely to occur.
    4. Examine the antecedents of the individual’s behaviors of concern including any internal or external factors that may trigger the behavior including whether the trigger is immediate or delayed. These antecedents may include physiological, psychological, social, or environmental triggers or a combination of some or all of these types of triggers.
    5. Determine if the behaviors of concern vary by setting (e.g., residential, vocational, or school).
    6. Develop a working hypothesis of the function or purpose the behaviors of concern may serve for the individual, such as a means of communication, regulation of emotional distress, modulation of physical discomfort, or social-environmental control.
    7. Indicate the length of time that the individual’s behaviors of concern have been exhibited. Determine if it is a variant of an older behavior that the individual has exhibited.
    8. Report any current psychosocial factors in the individual’s life which may cause the individual to exhibit the behaviors of concern.
    9. Indicate any skills deficits the individual has for which the behaviors of concern may be compensating.
    10. Report how staff and caregivers respond when the individual’s behaviors of concern occur.
    11. Obtain a history of the individual’s successes or failures with previous interventions.
15. To develop an appropriate positive behavior support program for an individual using elements of the individual’s FBA, a behaviorist shall:
    1. Identify the reasons that led to the development of the individual’s behavior support plan.
    2. Describe the ways in which the behaviors of concern (e.g., aggression, refusals) interfere with the individual’s performance, participation, and progress.
    3. Specify the rationale for the behavioral goals and objectives in the individual’s behavior support plan that are based on the information in the individual’s FBA.
16. Detail interventions in the plan, which correspond with the functional assessment of the individual’s behaviors of concern.
17. Determine methods to teach and positively reinforce socially appropriate alternative behaviors to help an individual meet his or her needs.
18. Identify which changes (e.g., eliminating triggers, predictable scheduling, access to soothing items) in the environment may help prevent or reduce the behaviors of concern.
19. Specify the methods employed to redirect behaviors of concern before or as they occur with an emphasis on proactive strategies, rather than reactive interventions.
20. Describe the hierarchy of interventions to be used if the individual’s behaviors of concern escalate.
21. Specify methods of documenting the individual’s behavioral crisis and debriefing after the crisis.
22. Incorporate person-centered planning (i.e., relative strengths, interests, preferences, skills, protective factors, and supports) into the development of the individual’s positive behavior support program. A behavior support plan shall contain achievable goals and measures to assess changes in the individual’s behaviors.
23. Focus the behavior support plan on quality of life enhancements for the individual, such as participation in pleasurable activities, opportunities for choice, building meaningful relationships, and inclusion in community activities.
24. Encourage a team approach (i.e., collaboration between the individual, his or her Planning and Support Team, and other stakeholders) to develop and implement the individual’s behavior support plan. Certain decisions on clinical or forensic matters made by a licensed mental health provider (e.g., psychiatrist or psychologist) that are intended to ensure the safety and security of the individual or other persons may not be subject to PST approval.
25. Specify the staff training requirements and methods for program evaluation, which may include in-service seminars, ongoing supervision and consultation, data reviews and checks of fidelity of treatment.
26. Establish criteria for determining the effectiveness of the individual’s behavioral support strategies that may include (1) meaningful improvements in the individual’s quality of life, (2) increased use of desired adaptive behaviors, (3) improved use of alternative coping skills, (4) decreased frequency, intensity, or duration of behaviors of concern, or (5) a reduction in crisis interventions by caregivers.
27. To develop appropriate data collection concerning the outcomes of an individual’s behavior support plan, a behaviorist shall:
28. Record data on the individual’s behaviors of concern which are being targeted by (1) medication, and (2) aversive procedures. Describe how the individual’s behaviors of concern are manifested (i.e., indicate what behaviors a direct care worker might observe.)
29. Record data on the individual’s skills that are being built as an alternative to his or her behaviors of concern.
30. Review data periodically to determine if changes in the individual’s positive behavior support program are needed. The data shall be shared with all of the individual’s support staff and with any physician or APRN who has prescribed medication. Any change in medication or dosage shall be based upon an assessment of the individual’s longitudinal data.
31. Develop and graph comparisons between an individual’s intervention data versus his or her baseline data to determine whether the treatment is effective. Graphs that are easily readable allow an opportunity to evaluate treatment effects on dynamic behavioral changes.
32. Annotate interaction effects on the graphs, such as medication changes, emergent health issues, revisions in behavioral strategies, increased engagement in meaningful activities, or changes in significant persons in the individual’s life. An interpretive summary of the individual’s data should be included with any graphs.
33. To develop a clinically appropriate psychiatric medication plan for an individual, a licensed prescriber shall:
34. Document that any psychiatric medication prescribed to an individual shall be used in conjunction with a behavior support plan that includes appropriate positive behavior supports.
35. Document that any psychiatric medications prescribed to an individual shall be for:

Mental health conditions that have been diagnosed according to the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of the Mental Disorders (DSM) and not solely for an individual’s diagnosis of intellectual disability or autism spectrum disorder.

Mental health conditions which are potentially responsive to the psychiatric medications being prescribed.

1. Document that the psychiatric medications prescribed to an individual have been approved by the U. S. Food and Drug Administration (FDA). The regional Program Review Committee may approve the off-label use of certain medications.
2. Document that the rationale for prescribing psychiatric medications to an individual be clearly articulated in the plan. Psychiatric diagnoses shall not be generated for the purpose of justifying the use of behavior modifying medications. The licensed prescriber may use I.E.PR.004 Attachment F Medication Prescriber’s Treatment Plan Optional Form.
3. Document any physical, neurological, environmental, and psychiatric factors that have been considered as part of the process in recommending the use by the individual of psychiatric medication.
4. Document that psychiatric medications are not being used because of a lack of staff, inadequately trained staff, or a lack of positive behavior supports.
5. Document that psychiatric medications are not being used in quantities that unnecessarily interfere with the individual’s habilitative programming
6. Document that the potentialbenefits of using the psychiatric medications outweigh the risks of not using these medications with the individual.

1. If psychiatric medications prescribed to an individual are part of a research or investigational study, a licensed prescriber or the individual’s Planning and Support Team shall:
   * 1. Document that consent was obtained from the individual or the individual’s guardian for the use of the investigational psychiatric medications.
     2. Document that any non-FDA-approved medications shall be administered by a licensed nurse or physician.
     3. Document that the research proposal and protocol were reviewed and approved by the DDS Institutional Review Board (IRB) according to DDS policy and procedure.
2. **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”

**State Statute and Regulation**

Section 17a-210 of the Connecticut General Statutes

Section 17a-238 of the Connecticut General Statutes

Section 45a-677 of the Connecticut General Statutes

Section 45a-677(e) of the Connecticut General Statutes

Section 46a-11, 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

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

I.F.PO.001 Abuse and Neglect Prevention

I.F.PR.001 Abuse and Neglect Prevention, Reporting, Notification, Investigation, Resolution and Follow-up

I.F.PR.006 Human Rights Committee

II.G.PO.001 Office of the Commissioner Institutional Review Board (IRB)

II.G.PR.001 Office of the Commissioner Institutional Review Board (IRB)

DDS Policy 1 Client Rights

DDS Policy 7 Programmatic Administrative Review

DDS Policy 13 Advocates

1. **Attachments**

I.E.PR.004 Attachment A [Request for PRC Date to Review Behavior Modifying Medication, Restraint or Aversive Procedure Form](http://www.ct.gov/dds/lib/dds/dds_manual/ie/behavior_support/iepr004_attachment_a_prc_request_form.docx)

I.E.PR.004 Attachment F [PRC Medication Prescriber's Treatment Plan](http://www.ct.gov/dds/lib/dds/dds_manual/ie/behavior_support/iepr004_attachment_f_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 [PRC Consent for Treatment Form](http://www.ct.gov/dds/lib/dds/dds_manual/ie/behavior_support/iepr004_attachment_g_prc_consent_fortreatment.docx)