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Rights of Persons Under the Supervision of the Commissioner of Mental Retardation

Sec. 17a-238-1. Definitions

For the purpose of Sections 17a-238-1 through 6 inclusive, the following definitions shall apply:

(a) **Department** and **Departmental** as used in these regulations refer to the Department of Mental Retardation.

(b) **Persons** or **clients** are individuals served by the Training Schools and Regional Centers under the supervision of the Commissioner of Mental Retardation.

(c) **Service** is any departmental program that provides: direct care and treatment; functional education; preacademic, academic, prevocational and vocational skills training; self-help skills training; therapy, counseling, recreation, and evaluations which include, but are not limited to, psychological, medical, social service, audiological and communication.

(d) **Corporal punishment** is the application of a painful stimulus to the body as a penalty for behavior, but does not include the contingent application of such a stimulus in an approved written behavior modification or behavioral therapy program which complies with federal and state regulations.

(e) **Therapy** is any of many methods utilized by many disciplines whose purpose is to enable the client to interact with and adapt to the environment so as to function in a manner which is adequate for his or her needs and for the development to full potential. These therapy methods include, but are not limited to, behavior modification and psychotropic drug therapy.

(f) **Restraint** is the use of any device or means to hold back, bind, tie, restrict, or otherwise prevent a client from doing something, and from which the client cannot voluntarily extricate himself or herself. Restraint shall include totally enclosed cribs. Supportive devices used in normative situations to achieve proper body position and balance shall not be considered to be restraints, provided that they are approved by a physician licensed to practice in the State of Connecticut.

(g) **Seclusion** is the placement of a client alone in a locked room, but does not include the contingent use of a time-out from positive reinforcement room when employed in an approved written behavior modification or behavior therapy program which complies with state regulations and departmental policy.

(h) **Force** is constraining or compelling the actions of another by physical means.

(i) **Habilitation** is the process by which the staff of the facility assists the client to acquire and maintain those life skills which enable the client to cope more effectively with the demands of that client's own person and environment, and to raise the level of the client's physical, mental and social efficiency. Habilitation includes, but is not limited to programs of formal, structured education and treatment.

(j) **Treatment** shall refer to and be synonymous with therapy.

(k) **Emergency intervention** as here defined refers to the actions staff shall take in response to a situation which threatens health or life as a result of self-injury and/or violent assaultive behavior toward others.

(l) **Staff** shall include anyone employed by the Department, the Training Schools, the Regional Centers and any other authorized person having direct contact with, or responsibilities for, clients.

(m) **An individual "plan of care"** is a written plan setting forth goals or behaviorally stated objectives and prescribing an integrated program of individually designed activities, experiences, training, or therapies necessary to achieve such

goals or objectives. The overall objective of the plan is to attain or maintain the optimal physical, intellectual, emotional, social or vocational functioning of which the individual is presently or potentially capable. "Individual plan of care" and "individual program plan" are used interchangeably hereafter.

(n) **Training** as herein defined refers to a systematic and planned application of procedures in the form of a formal written behavior program for the purpose of helping a client acquire and/or maintain behaviors, skills and capabilities.

(o) **Chemical Restraints** as here defined are drugs such as tranquilizers or other psychopharmacologic agents which are used for the purpose of controlling or limiting behavior.

(Effective August 24, 1994)

Sec. 17a-238-2. Corporal punishment

(a) Staff shall not use corporal punishment on clients.

(Effective August 24, 1994)

Sec. 17a-238-3. Emergency procedures

(a) Staff shall not use restraint or force upon a person except as an emergency intervention or as an integral part of an individual program plan.

(b) Physical restraint shall be employed only when absolutely necessary to protect clients from injury to themselves or to others. Restraint shall not be employed as a punitive measure, for the convenience of staff, or as a substitute for program in accordance with Sec. 249.13 (b) (1) (xi) (A) through (E) of the Federal ICF/MR Standards.

(c) Force shall be employed only when absolutely necessary and only to the extent essential to protect clients from injury to themselves or to others. Force shall not be employed as a punitive measure for the convenience of staff, or as a substitute for program.

(Effective August 24, 1994).

Sec. 17a-238-4. Seclusion

(a) Staff shall not use seclusion, in accordance with Sec. 249.13 (b) (1) (x) of the Federal ICF/MR Standards.

(Effective August 24, 1994)

Sec. 17a-238-5. Chemical restraint

(a) Chemical restraints shall not be used as a punitive measure, for convenience of staff, as a substitute for program, or in quantities that interfere with a client's habilitation program in accordance with Sec. 249.13 (b) (1) (xii) of the Federal ICF/MR Standards.

(b) The use of chemical restraints shall be authorized in writing by a licensed physician for accepted therapeutic reasons and for a specified period of time as an integral part of the client's habilitation program.

(c) The written authorization for chemical restraints shall specify the behavior to be controlled or limited and the data that are to be collected in order to assess progress toward the treatment goal.

(Effective August 24, 1994)

Sec. 17a-238-6. Use of therapies

(a) Staff shall utilize therapy procedures only when indicated by a client's habilitation program.

(b) The client's habilitation program shall indicate which therapies shall be used.

(c) Therapy programs shall be designed and supervised by staff who are qualified mental retardation professionals in accordance with Sec. 249.13 (h) (iii) of the Federal ICF/MR Standards, within their respective areas of professional competence. (Effective August 24, 1994)

Approval Procedures for use of Aversives for Persons Placed or Treated Under the Supervision of the Department of Mental Retardation

Sec. 17a-238-7. Preamble

Notwithstanding any general statutes or regulations to the contrary, Sections 17a-238-7 to 17a-238-13, inclusive, establish comprehensive procedures for the development and review of behavioral support plans or courses of treatment, for persons placed or treated under the direction of the commissioner, which include the use of aversive procedures in accordance with subsection (b) of section 17a-238 of the Connecticut General Statutes. In establishing these procedural safeguards the department affirms its commitment to positive behavioral supports and therefore demands rigorous adherence to these procedures whenever programs and plans are proposed which include the use of aversive procedures.

(Effective November 17, 1994)

Sec. 17a-238-8. Definitions

For purposes of Sections 17a-238-7 thru 17a-238-13 the following definitions shall apply:

(1) "Aversive device" means an instrument used to administer an electrical shock or other noxious stimulus to an individual to modify undesirable behaviors.

(2) "Aversive procedure" means the contingent use of an event which may be unpleasant, noxious or otherwise cause discomfort to (1) alter the occurrence of a specific behavior or to (2) protect an individual from injuring himself or others and may include the use of physical isolation and mechanical and physical restraint.

(3) "Behavioral support plan" means a written document developed to address an individual's behaviors which interfere with the implementation of the goals and objectives in the individual's annual plan. If the use of aversive procedures to protect the individual from harming himself or others is reasonably anticipated to be needed, these specific procedures shall be included in the plan.

(4) "Commissioner" means the commissioner of mental retardation.

(5) "Department" means the department of mental retardation.

(6) "Emergency" means the demonstration of a serious behavioral problem which may adversely affect the health or safety of the individual or others and for which a behavioral support plan has not been developed or approved; or for which a previously designed behavioral support plan is not effective.

(7) "Functional analysis" means 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 will occur across the full range of typical daily routines; (3) a definition of the function the undesirable behavior produces for the individual; (4) an understanding of the environmental, interpersonal, and other ecological factors that shall be considered in order to develop an effective positive programmatic response to the behavior.

(8) "Human rights committee" means a group of individuals who are not employees of the department, who provide monitoring to ensure the protection of legal and human rights of individuals with mental retardation.

(9) “Interdisciplinary team” means a group of people that includes the individual being served, his family, guardian or advocate, those people who work most directly with the individual in each of the professions, disciplines, or service areas that provide service to the individual, including direct care staff, and any other people whose participation is relevant to identifying the needs of the individual.

(10) “Mechanical restraint” means any apparatus used in an aversive procedure that restricts individual movement excluding mechanical supports designed by a physical therapist and approved by a physician that are used to achieve proper body position or balance and helmets used to protect an individual from injuries due to falls caused by seizures. Helmets, mitts and similar devices used to prevent self injury are considered mechanical restraints.

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

(12) “Physical restraint” means the aversive procedure of physically holding an individual to restrict movement or to prevent the individual from harming himself or others.

(13) “Positive behavioral support” means an integrated approach to teach an individual adaptive and socially appropriate skills. Such supports may include teaching strategies and/or environmental supports to increase adaptive behaviors, and decrease maladaptive behaviors. Such supports should treat the individual in a respectful, age-appropriate manner, should be built into the individual’s daily schedule, and should occur in a natural context. The individual and his family, advocate and support staff should be involved in the design of the positive behavioral supports.

(14) “Program review committee” means a group of professionals, including a psychiatrist, assembled to review individual programs and behavior modifying medications to ensure that they are clinically sound, supported by proper documentation, and are being proposed for use in conformance with departmental policies.

(Effective November 17, 1994)

Sec. 17a-238-9. Prohibitions

(a) No behavioral support plan or course of treatment for any person placed or treated under the direction of the commissioner shall include the use of an aversive device which has not been tested for safety and efficacy and approved by the Federal Food and Drug Administration.

(b) No behavioral support plan or course of treatment prescribed for any person placed or treated under the direction of the commissioner shall include the use of aversive procedures except in accordance with Sections 17a-238-10 and 17a-238-11 of these regulations.

(c) No training curriculum for the use of aversive procedures, physical restraint procedure, mechanical restraint apparatus or certain forms of physical isolation which are not presently approved by the department may be used for any person placed or treated under the direction of the commissioner without prior approval in accordance with Section 17a-238-13 of these regulations.

(d) The use of a room specifically designed for physical isolation and the use of a locked door for any physical isolation are prohibited.

(Effective November 17, 1994)

Sec. 17a-238-10. Approval process for behavioral support plans which include aversive procedures

Aversive procedures shall be reviewed and approved as follows:

(a) The interdisciplinary team shall identify the need for a behavioral support plan.

(b) Staff with appropriate training and experience in positive behavioral supports shall be assigned to design and implement the plan. All plans shall include and emphasize components designed to increase positive behaviors and be based on a completed functional analysis.

(c) The functional analysis shall be:

(1) conducted by, or under the supervision of a person who has documented training in behavior analysis with an emphasis on positive behavioral support; and

(2) based on direct observation of the individual, interviews with significant others, and review of available data such as assessment reports prepared by other professionals.

(d) The functional analysis shall include:

(1) an interview with the individual or those who know him best;

(2) a systematic observation of the occurrence of the undesirable behavior over an extended period of time for an accurate definition and description of the frequency, duration and intensity;

(3) a systematic observation of the immediate antecedent events associated with each instance of the display of the undesirable inappropriate behavior;

(4) a systematic observation and analysis of the consequences following the display of the behavior to determine the function the behavior serves for the individual, i.e., to identify the specific environmental or physiological outcomes produced by the behavior;

(5) an analysis of the communicative intent of the behavior, identified in terms of what the individual is either requesting or protesting through the display of the behavior;

(6) an ecological analysis of the settings in which the behavior occurs most frequently. Factors to consider shall include the physical setting, the social setting, the activities and the nature of instruction, scheduling, the quality of communication between the individual and staff and other individuals, the degree of independence, the degree of participation, the amount and quality of social interaction, the degree of choice, and the variety of activities;

(7) a review of records for health and medical factors which may influence behaviors (e.g. medication levels, sleep cycles, health, diet, psychological or neurological factors); and

(8) a review of the history of the behavior to include the effectiveness of all previously used behavior supports and interventions.

(e) **Behavioral Support Plan Development**

A behavioral support plan based on the functional analysis and emphasizing positive behavioral interventions shall be developed and shall include:

(1) baseline data;

(2) evidence that the individual or others will be harmed more by the undesirable behavior continuing than by the application of the procedure;

(3) a statement from a physician that the proposed aversive procedure is not medically contraindicated;

(4) methods for increasing positive behaviors and decreasing undesirable behaviors;

(5) objective and specific definitions of the undesirable behaviors;

(6) methods for measuring the undesirable behaviors and positive behaviors to be learned or increased;

(7) consequences for the undesirable behaviors;

(8) a plan for reducing or eliminating the use of the aversive procedure;

- (9) criteria for reducing or eliminating the use of the aversive procedures;
 - (10) the circumstances under which the aversive procedure shall be used and a procedure for supervising implementation of the intervention;
 - (11) who shall be responsible for monitoring the behavioral support plan;
 - (12) a graph or other data summary of both positive and undesirable behavior, over the life of the intervention;
 - (13) a plan for providing any staff training; and
 - (14) a plan for integration of the program in all settings as appropriate.
- (f) The interdisciplinary team shall approve the behavioral support plan and designate the person who may authorize administration of the plan if the plan is approved. The plan author, the case manager and other necessary interdisciplinary team members shall present the proposed plan to the program review committee for review.
- (g) The program review committee shall review all behavioral support plans using aversive procedures for clinical appropriateness. This review shall include:
- (1) a comprehensive review of previous plans to ensure that positive or less aversive techniques have been tried and found to be ineffective or are not clinically appropriate; and that the aversive procedures are not being used due to lack of staff, inadequately trained staff, or lack of positive behavioral interventions;
 - (2) assurance that the plan is appropriate for the individual based on a functional analysis as defined in Section 17a-238-8 of these regulations;
 - (3) assurance that the plan includes:
 - (A) positive behavioral supports
 - (B) baseline data
 - (C) clearly defined objectives
 - (D) techniques
 - (E) data collection methods and reliability checks
 - (F) length of treatment
 - (G) review schedule
 - (H) plan for reduction in use of aversive procedures
 - (4) assurance that adequate and consistent staff and resources are available to implement the plan;
 - (5) assurance that the plan for training staff in the procedures to be used is appropriate and that staff training is documented; and
 - (6) assurance that the plan is implemented as designed.
- (h) The individual, parent, guardian or advocate, or person familiar with the individual shall be encouraged to attend the program review committee meeting for the purpose of hearing the presentation and presenting any opposing views.
- (i) The program review committee (including a representative from the human rights committee) shall recommend approval or disapproval of the plan to the regional or training school director.
- (j) If the human rights committee representative finds that the plan or its review presents a human rights problem, he shall notify the regional or training school director who shall ensure a human rights committee review within thirty (30) days prior to approving any use of the procedure even on a temporary basis.
- (k) If the human rights committee representative identifies no human rights problem, temporary approval may be recommended on behalf of the human rights committee.
- (l) The plan and the program review committee's recommendations shall be sent to the human rights committee in all cases.

(m) The human rights committee shall review the plan and program review committee findings and provide a written recommendation to the regional or training school director within 30 days of receiving the plan from the program review committee.

(n) After considering the recommendations of the program review committee the regional or training school director shall, within ten (10) days, approve or disapprove the plan.

If the regional or training school director decides to approve the plan despite the program review committee or human rights committee recommendation for disapproval, the reason for the approval along with the plan and the committee's recommendations shall be sent to the commissioner. The commissioner shall concur with the plan approval before it may be implemented.

(o) Any plan that includes the use of an aversive device or provisions which inflict pain to affect an undesirable behavior of any individual which is recommended for approval by the program review committee, the human rights committee and the regional or training school director, shall require approval by the commissioner before implementation.

(Effective November 17, 1994)

Sec. 17a-238-11. Emergency use of physical or mechanical restraint

(a) Physical or mechanical restraint may be employed when an emergency exists in which a person placed or treated under the direction of the commissioner is in jeopardy of harming himself or others and approved individual programs are ineffective to control the situation.

(b) Nonaversive measures shall be attempted first to prevent escalation of the emergency. If such measures are ineffective, emergency use of physical or mechanical restraint may be necessary. No aversive procedure other than physical or mechanical restraint may be employed in an emergency.

(c) Each organization operated, licensed or funded by the department shall establish general written procedures to be used in emergencies. These procedures shall designate supervisory or professional staff who may authorize the use of physical or mechanical restraint in an emergency and shall identify the techniques, devices and equipment which may be used.

(d) A member of the program review committee shall be notified not later than the next working day and shall monitor any continuing use of physical or mechanical restraint until a program is formally approved and commences. Documentation of monitoring shall be maintained in the individual's record.

(e) Whenever physical or mechanical restraint is employed during an emergency, supervisory or professional staff shall examine the individual within twenty-four (24) hours and report any evidence of trauma or injury to the nurse or physician and to the regional or training school director.

(f) The interdisciplinary team, including the physician, shall, within three (3) working days of the use of emergency physical or mechanical restraint, review the individual and his environment to determine if changes are required in his program including the continued use of physical or mechanical restraint or if other behavioral supports should be considered. The interdisciplinary team shall initiate design of a behavioral support plan and the approval process set forth in Section 17a-238-10 of these regulations within five (5) days of the interdisciplinary team review, if:

(1) the interdisciplinary team determines that the continued use of physical or mechanical restraint is necessary; or

(2) the interdisciplinary team proposes the use of other aversive procedures; or
(3) physical or mechanical restraint is used on an emergency basis three (3) or more times in a thirty (30) day period; or

(4) physical or mechanical restraint is used one or more times in three (3) consecutive thirty day (30) day periods.

(g) A report of the interdisciplinary team review, whatever the programmatic outcome, shall be submitted to the program review committee, the human rights committee and the regional or training school director.

(h) Each incident of physical or mechanical restraint used to address an emergency shall be reported in writing to the program review committee, the human rights committee and the regional or training school director within three days of the incident.

(i) Standing orders for the emergency use of mechanical restraint are prohibited.
(Effective November 17, 1994)

Sec. 17a-238-12. Department approved aversive procedures

(a) The implementation of the following department approved procedures shall be in accordance with Sections 17a-238-10 and 17a-238-11 of these regulations:

(1) The department's staff development division maintains a listing of currently approved training curricula in the use of aversive and physical restraint procedures.

(2) The department's staff development division maintains a listing of restraint apparatus approved by the department.

(3) The use of forms of physical isolation which are aversive, but not otherwise prohibited by these regulations, (e.g., the individual is prevented from leaving the area or room; or criteria are placed on the ending of isolation) are permitted by the department subject to the approval process set forth in Section 17a-238-10 of these regulations.

(b) The approval of any new procedure shall be in accordance with section 17a-238-13 of these regulations and the implementation of such new procedure shall be in accordance with sections 17a-238-10 and 17a-238-11 of these regulations.

(Effective November 17, 1994)

Sec. 17a-238-13. Approval process for training curricula, physical restraint procedures, restraint apparatus and forms of physical isolation

(a) Any proposals for the use of new training curricula, physical restraint procedures, restraint apparatus or forms of physical isolation not previously approved by the department shall be submitted in writing to the commissioner for review and approval.

(b) The commissioner shall appoint a committee of not more than five members all of whom shall be familiar with the department approved aversive procedures, two of whom shall be members of regional program review and human rights committees, and one who shall be a certified trainer in department approved procedures.

(c) The committee shall compare the proposal to those which are currently approved by the department and make a recommendation to the commissioner.

(d) The commissioner shall approve or disapprove the proposal based on the committee's recommendation. If the commissioner decides to approve a proposal over the committee's recommendation to disapprove, the reason for the approval shall be documented by the commissioner and sent to members of the committee.

(Effective November 17, 1994)