State of Connecticut
Department of Developmental Services

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Commissioner

Peter Mason
Deputy Commissioner

Behavior Oversight Committee Memo FY2022-01

To: DDS Qualified Clinical-Behavioral Providers

From: Peter Tolisano, Psy.D., ABPP, Co-Chair, Behaviorist Oversight Committee

CC: Jordan Scheff, Commissioner, Peter Mason, Deputy Commissioner, Krista Ostaszewski, Health Management Administrator, Regional Directors, Regional Clinical Directors, Assistant Regional Directors, Regional Nursing Directors, Debra Lynch, Operations Specialist, Provider Specialists, The Alliance, All DDS Qualified Providers

Date: December 20, 2021

Re: Content of Behavior Support Plans

This memo is to provide agencies and individual practitioners with clarification and guidance regarding the development of behavioral support plans for individuals served by DDS.

1. *Clinicians qualified by DDS who are authoring and updating behavior support plans should be the same practitioner who oversees implementation and data collection for the abovementioned document.*

2. Behavior support plans, based either on Applied Behavioral Analysis or Positive Behavior Supports, should include the following items in their content:

   - **Personal History** including information about demographics, significant medical conditions, traumatic and life-altering experiences, levels of intellectual and adaptive functioning, individual strengths/weaknesses, personal preferences, and unique interests.

   - **Relevant Background** describing psychiatric diagnoses, neuropsychological impairments, mental status changes, psychosocial stresses, family and cultural issues, salient risk factors, legal or criminal involvement, and past/present substance abuse.

   - **Referral Questions** regarding the reasons that prompted the need for behavioral interventions.

   - **Rationale for Interventions** that discuss the factors that influence the behavioral presentation, successes and failures of past interventions, type of supervision required, and the levels of service and need (per DDS).

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- **Functional Assessment** that offers hypotheses about the purpose of challenging behaviors. This process should include information about antecedents, setting events, vulnerabilities, and maintaining consequences. *Identified functions should clearly correspond to the interventions selected, as replacement behaviors are a key element in the development of a sound behavioral approach.*

  Note: the maximum billable hours for an initial functional assessment and development of a behavior plan range from 8 to 12 hours. Ongoing data collection and adjustments are incorporated into the monthly rate.

- **Identification of Behaviors of Concern.** That is, those that affect health and safety, pose a barrier to progress, hinder adaptation, and relate to the rationale for psychiatric medication prescribing.

- **Identification of Targeted Positive Behaviors** that highlight the adaptive and prosocial behaviors to be achieved and methods to build skills, interests, and strengths. *Plans that focus exclusively on achieving an absence of maladaptive behaviors are often deemed to be inadequate.*

- **Emphasis on Proactive and Preventative Interventions** including the setting of expectations, reinforcing adaptive behavior, and minimizing/eliminating triggers.

- **Inclusion of Reactive/Restrictive Interventions**. These interventions, for limited use only, are developed to establish calmness and ensure safety. They may include neutral and empathic validation, sensory modalities, redirection, limit setting, restraint interventions, and enhanced staffing. If it is not safe to immediately discontinue restrictive interventions, then criteria for their titration should be developed in the form of a fading plan.

- **Lifestyle Enhancements**. That is, ways to improve an individual's quality of life with new interests, pleasurable activities, and meaningful relationships.

- **Methods for Data Collection**. Data collection methods may include A-B-C forms, continuous monitoring (frequency, intensity, rate, duration, or latency), and discontinuous measures (partial interval, whole interval, or momentary time sampling).

- **Representation of Data.** Data tables should be presented along with graphical representations that include baselines. It is recommend that phase-lines are used with the introduction of new interventions or medications. Ensure that the author of the behavior plan provides the data interpretation on behavioral reports and that adjustments are made to the plan as necessitated.

- **Documentation and Training Requirements**. That is, the methods used to ensure fidelity to the plan including training done by the plan author, training by caretakers on the plan, or a train-the-trainer approach.

- **Incorporation of Team Approach**. Input from the person-served and recommendations from stakeholders and other supportive resources. Caveat: There may be instances where the team elects to exclude the individual served from the decision-making process due to health and safety concerns.

- **Criteria for Success** including ways to determine the effectiveness of the plan, such as measurable goals for problem behavior reduction and tracking of the individual's engagement in alternative coping skills.

If you have any questions, please contact Dr. Peter Tolisano, DDS Director of Psychology at 860-418-6086 or Peter.Tolisano@ct.gov