

<b>Community Mental Health Partnership of Southeast Michigan/PIHP</b>	<b><i>Policy Behavior Treatment Committee</i></b>
<b>Committee/Department: Clinical Performance Team</b>	<b>Local Policy Number (if used)</b>
<b>Implementation Date 03/11/2022</b>	<b>Regional Approval Date 02/25/2022</b>

<b>Reviewed by:</b>	<b>Recommendation Date:</b>
ROC	01/12/2022
<b>CMH Board:</b>	<b>Approval Date:</b>
Lenawee	01/27/2022
Livingston	01/25/2022
Monroe	02/23/2022
Washtenaw	02/25/2022

## I. PURPOSE

To establish policy for Behavior Treatment Committees (BTC) with the responsibility for reviewing restrictive and/or intrusive treatment plans and reviewing policies for the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

## II. REVISION HISTORY

<b>DATE</b>	<b>MODIFICATION</b>
12/09/2009	Policy creation
08/28/2013	Revised to reflect the new regional entity effective January 1, 2014.
07/30/2014	Revisions to reflect the MDCH FY 14 Contract Attachment
09/21/2017	3-year review/update
02/25/2022	3-year review

## III. APPLICATION

All staff, students, volunteers and/or contractual agencies within the CMHPSM. This policy does not apply to those external entities/providers that are not in a contractual relationship with the CMHPSM that may prescribe medications to consumers/individuals who receive services in the CMHSPM system (i.e., dentists, primary care physicians).

## IV. POLICY

The Behavior Treatment Committee shall be a standing committee within each Community Mental Health Services Program (CMHSP) in the CMHPSM. The BTC shall review **and** approve or disapprove any treatment plans that propose to use any behavioral management techniques as defined in this policy.

## V. DEFINITIONS

Applied Behavior Analysis - is the organized field of study which has, as its objective, the acquisition of knowledge about behavior using accepted principles of inquiry

based on operant and respondent conditioning theory and functional assessment of behavior. It also refers to a set of techniques for modifying behavior toward socially meaningful ends based on these conceptions of behavior.

Aversive Techniques - are those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequence behavior or to accomplish a negative association with target behavior, use of nausea-generating medication to establish a negative association with target behavior or for directly consequence target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.

Behavior Modification - is the systematic application of principles of general behavior theory to the development of adaptive and/or the elimination of maladaptive behavior consistent with therapeutic objectives through the use of a variety of recognized techniques including but not limited to shaping, positive reinforcement, and other techniques based on general behavior theory.

Community Mental Health Partnership of Southeast Michigan (CMHSPM) - the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services through contract with the Michigan Department of Health and Human Services (MDHHS).

Community Mental Health Services Program (CMHSP) - A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Intrusive Techniques: - are those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug that is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Peer-Reviewed Literature: - Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered

authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Physical Management: - A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. The term “physical management” does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is **prohibited under any circumstances.**

Positive Behavior Support: - A set of research-based strategies used to increase *quality of life* and decrease problem behavior by teaching new skills and making changes in a person’s environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce problem behaviors such as self-injury, aggression, property destruction, pica, defiance and disruption.

Practice or Treatment Guidelines: - Guidelines published by professional organizations such as the American Psychiatric Association (APA) or the federal government.

Restraint: - Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of the consumer/individual served to move his or her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. This definition excludes anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual’s physical functioning. The definition also excludes safety devices required by law, such as car seat belts or child rear seats used while riding in vehicles. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital.

Restrictive Techniques: - Those techniques which will result in the limitation of the individual’s rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purpose of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Restrictive techniques include the use of a drug or medication when it is used as a restriction to manage, control or extinguish an individual’s behavior or restrict the individual’s freedom of movement and is not a standard treatment or dosage for the individual’s condition. Use of restrictive techniques requires the review and approval of the Committee.

Seclusion: - The placement of an individual in a room alone where egress is prevented by any means. Seclusion is **prohibited** except in a hospital or center operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Special Consent – Obtaining the prior written approval of the consumer/individual served, legal guardian, the parent with legal custody of a minor child or designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual’s rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the consumer/individual served, guardian or parent of a minor consumer/individual served may only occur when the consumer/individual served has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518 or 519 of the Mental Health Code.

Time Out – A voluntary response to the therapeutic suggestion to a consumer/individual served to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome. (MDHHS) Admin Rules definition).

Therapeutic De-escalation – An intervention where the implementation is incorporated in the individualized written plan of service, wherein the consumer/individual served is placed in an area or room, accompanied by staff who shall therapeutically engage the consumer/individual served in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

## VI. V. STANDARDS

- A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. If the CMHSP delegates the functions of the BTC to a contracted mental health service provider, the CMHSP must monitor the BTC to assure compliance with this policy.
- B. The BTC shall be comprised of at least three individuals, one of whom shall be a licensed psychologist with the specified training and experience in applied behavioral analysis; at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL330.1100c(10). Membership shall also include a person(s) external to the organization. A representative of the Office of Recipient Rights (ORR) shall participate on the Committee as non-voting member to provide consultation and technical assistance to the Committee for consideration of any rights related issues. Other non-voting members may be added at the BTC’s discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.
- C. The BTC, and BTC chair, shall be appointed by the agency for a term of not more than two years. Members may be reappointed to consecutive terms.

- D. The BTC shall meet as often as cases requiring review dictate. Plans with intrusive or restrictive techniques require minimally a quarterly review. (See G).
- E. The BTC shall keep all its meeting minutes, and clearly delineate the actions of the BTC.
- F. The BTC shall ask that a BTC member who has prepared a behavior treatment plan to be reviewed by the BTC recuse themselves from the final decision-making.
- G. The functions of the BTC shall be:
  - Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management or seclusion or restraint in a setting where it is prohibited by law or regulations.
  - Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques (see definitions).
  - Determine whether causal analysis of the behavior has been performed; whether positive behavior supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
  - For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency determined by the BTC or more frequently if clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavioral treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary; the more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the BTC.
  - Ensure that inquiry has been made about any medical, psychological or **other** factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
  - Once a decision to approve a behavior treatment plan has been made by the BTC and written special consent to the plan (see limitations in definition of special consent) has been obtained from the consumer/individual served or the legal representative it becomes part of the person's written Person-Centered Plan (PCP). The individual or legal representative has the right to request a review of the written PCP, including the right to request that person-centered planning be re-convened in order to revisit the behavior treatment plan. (MCL 330-1712(2)).
- H. On a quarterly basis the BTC will track and analyze the use of all physical management for emergencies and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
  - Dates and numbers of interventions used

- The settings (e.g., group home, day program) where behaviors and interventions occurred
  - Behaviors that initiated the techniques
  - Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention
  - Description of positive behavioral supports used.
  - Behaviors that resulted in termination of the interventions
  - Length of time of each intervention
  - Staff development and training and supervisory guidance to reduce the use of these interventions
  - Review and modification or development, if needed, of the individual's behavior plan.
- I. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program and be available for MDHHS review. Physical management, permitted for intervention in emergencies only, is considered a critical incident that must be analyzed by the BTC and the QAPIP or QIP and reported to MDHHS on a quarterly basis per mutually agreed upon data elements. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event that must be reported to MDHHS on a quarterly basis.
- J. In addition, the BTC may:
- Advise and recommend to the agency the need for specific staff or home-specific training in a culture of gentleness, positive behavior supports and other individual-specific non-violent interventions
  - Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm. In addition, the BTC might recommend a limit for the number of emergency interventions that can be used with an individual in a defined period before the mandatory initiation of a process that includes assessments and evaluations, and possible development of a behavior treatment plan, as described in this policy.
  - At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agency's needs and approved in advance by the agency.
  - Advise the agency regarding administrative and other policies affecting behavior treatment and modifications practices.
  - Provide specific case consultation as requested by professional staff of the agency.
  - Assist in assuring that other related standards are met, e.g., positive behavior supports.
  - Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.
- K. Prohibited Program Plans:
- Aversive techniques – Those techniques which require the deliberate

infliction of painful stimulation (or stimuli which would be painful to the average person) to achieve their effectiveness. Aversive techniques are prohibited and not utilized by any staff or program providing services.

- Procedures that deny any basic needs, such as nutritional diet, water, shelter, and essential, safe and appropriate clothing
- Corporal punishment
- Fear-eliciting procedures
- Any behavior management and treatment intervention that is implemented by another client
- Mechanical restraint, seclusion or time-outs
- Any procedure that is a psychological risk to the consumer/individual served
- Any technique that violates the dignity and respect of the consumer/individual served

## BEHAVIOR TREATMENT PLAN STANDARDS

- A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that assessments have been conducted to rule out physical, medical or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavior supports and interventions, to change the behavior.
- B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual or his/her legal representative prior to the implementation of the behavior plan.
- C. Behavior treatment plans that propose to use physical management in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the BTC.  
Utilization of physical management in emergency situations, or requesting law enforcement, may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30-day period the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. Inclusion of emergency interventions is prohibited as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.
- D. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the BTC.
- E. Plans that are forwarded to the BTC for review shall be accompanied by:
  - Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior
  - A functional assessment
  - Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of

- death, injury or trauma
- Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
- Evidence of continued efforts to find other options.
- Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention
- References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available.
- The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

## **VII. REFERENCES**

- A. 1997 federal Balanced Budget Act at 42 CFR 438.100
  - B. MCL 330.1712, Michigan Mental Health Code
  - C. MCL 330.1740, Michigan Mental Health Code
  - D. MCL 330.1742 Michigan Mental Health Code
  - E. Michigan Department of Health and Human Services Administrative Rule 330.719(2)(g)
  - F. Standard of Care on Medications – CMHPSM Prescriber Group
- MDHHS/CMHSP Managed Mental Health Services and Supports Contract FY21 Attachment C.8.8.3.1