

**Community Mental Health Affiliation  
of Mid-Michigan**

<b>PROCEDURE #:</b> 2.7	Page 1 of 6	<b>SUBJECT:</b> Behavior Treatment Plan Review Committees
<b>Related Policy(ies) #:</b> 2.0		<b>SUBJECT:</b> Clinical Policy
<b>Issuing Director:</b> Director of Affiliation Operations		<b>Original Effective Date:</b> 05/19/09

**REVISED DATE**

01/21/2010

**Review Date(s)**


**I. PURPOSE:**

To guide the PIHP in establishing Behavior Treatment Plan (BTP) Committees to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals who exhibit seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm.

**II. STANDARDS:**

42 CFR 438.100, Enrollee Rights  
MCL 330.1712, Michigan Mental Health Code  
MCL 330.1740, Michigan Mental Health Code  
MCL 330.1742, Michigan Mental Health Code  
Department of Community Health Administrative Rule 330.7199(2)(g)  
MDCH Technical Requirement for Behavior Treatment Plan Review Committees, 7/28/08  
JCAHO: Definition of a Sentinel Event

**III. DEFINITION(S):** (if applicable)

**A. Aversive techniques:**

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 consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating 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.

**B. Critical Incident:**

A Critical Incident is a relatively brief occurrence involving injury, loss, conflict, discovery or change of significant proportion, usually unscripted and unanticipated. Critical incidents are usually traumatic, threatening the bonds of trust between a consumer, staff and stakeholders

that left unaddressed may have adverse consequences. If repeated, a critical incident may become a sentinel event.

**C. Intrusive techniques:**

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 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.

**D. 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.

**E. 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 circumstance.**

**F. 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.

**G. Practice or Treatment Guidelines:**

Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

**H. Restraint:**

Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of the recipient 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 car 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.

**I. Restrictive Techniques:**

Those techniques which, when implemented, 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 purposes 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.

**J. 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.

**K. Sentinel Event:**

Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a person or persons, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a high risk of a serious adverse outcome.

**L. Special Consent:**

Obtaining the written consent of the recipient, the legal guardian, and the parent with legal custody of a minor child or a 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 recipient, guardian or parent of a minor recipient may only occur when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

**IV. PROCEDURES:**

A. Each CMHSP shall have a Behavior Treatment Committee to review and approve or disapprove any plan that proposes to use restrictive or intrusive interventions.

1. Membership: at least 3 members including:
  - a. Licensed psychologist with training and experience in applied behavior analysis
  - b. Licensed physician/psychiatrist
  - c. Recipient Rights officer shall be an ex-officio, non-voting member
  - d. Other non-voting members may be added with the consent of the consumer whose plan is being reviewed.
2. The Committee and Committee chair shall be appointed by the CMHSP for a term of not more than 2 years. The members may be reappointed to consecutive terms.
3. The committee shall meet as often as needed but no less than monthly.
4. The committee shall keep minutes that clearly delineate the actions of the committee.
5. A committee member who has prepared a Behavior Treatment Plan (BTP) for review shall recuse him/herself from the final decision-making on that plan.

B. Functions of the Behavior Treatment Committee:

1. Approve only BTPs that do not contain techniques prohibited by law or regulations including:

- a. aversive techniques
  - b. physical management
  - c. seclusion
  - d. restraint
2. Review all BTPs that contain intrusive or restrictive techniques.
  3. Ensure that causal analysis of the behavior has been performed and positive behavioral techniques pursued before approving the plan.
  4. Every BTP shall be reviewed quarterly, or more often when more intrusive and Aversive techniques are used more frequently.
  5. Ensure that the person to whom the plan pertains has been screened for potential medical, psychological or other factors that may place him/her at risk for an adverse outcome.
  6. Following approval of the BTP by the committee and the individual/guardian/ parent with legal custody of a minor or designated patient advocate, it will become part of the written individual plan of service (IPOS).
  7. The individual/guardian parent with legal custody of a minor or designated patient advocate has the right at any time to request that person-centered planning committee be reconvened to reconsider the BTP.
- C. Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually.
- D. Behavior management data will be collected for analysis and made available to the PIHP Behavior Treatment Plan Committee for review:
- The data collected shall include the following:
1. The use of emergency physical management and the use of intrusive and restrictive techniques by each individual receiving the intervention.
  2. Dates and numbers of interventions used.
  3. The settings where behaviors and interventions occurred
  4. Behaviors that resulted in use of the techniques.
  5. Attempts to use positive behavioral supports
  6. Behaviors that resulted in termination of the interventions
  7. Length of time of each intervention
  8. Staff development, training and supervisory guidance to reduce use of the interventions.
- E. Data on the use of intrusive and restrictive techniques will be:
1. Submitted to and evaluated by the PIHP's Behavior Treatment Committee quarterly
  2. Available for review by MDCH
- F. Emergency physical management:
1. Is treated as a critical incident
  2. Must be analyzed by the BTP Committee
  3. Must be reported to the PIHP's Behavior Treatment Committee and MDCH quarterly
  4. Must be reported to the PIHP Director of Quality within 1 business day if the occurrence has the potential to be a critical incident or a sentinel event.
  5. That is determined to be a sentinel event must be reported to MDCH quarterly.
- G. In addition, a BTP Committee may:
1. Advise and recommend specific staff training in positive behavioral supports and other interventions.
  2. Advise and recommend to the PIHP BTP Committee other interventions that may be used in emergency or crisis situations when a BTP does not exist for an individual. It may also limit the number of emergency interventions that can be used in a specified period of time before the mandatory initiation of assessments and the development of a BTP.

3. Review other formal BTPs if consistent with the CMHSP's needs and is approved in advance by the CMHSP.
  4. Provide specific case consultation when requested by professional staff.
  5. Assist in assuring that other related standards are met, e.g. positive behavioral supports.
  6. Serve another entity (e.g. sub-contractor) if agreed upon by the involved parties.
  7. Request a consultation with the PIHP Behavior Treatment Plan Oversight Committee.
- H. Behavior Treatment Plan standards:
1. Person centered planning process will identify when a BTP needs to be developed and where documentation of assessments to rule out physical, medical or environmental causes of the behaviors and use of positive behavioral supports and interventions have failed to change the behavior.
  2. BTPs:
    - a. Must be developed through the PCP process
    - b. Have written consent by the individual, guardian, or parent of minor child prior to implementation of the plan.
    - c. That include non-emergent physical management, aversive techniques or seclusion or restraint in a setting where they are prohibited by law, will not be approved.
    - d. That propose to use restrictive or intrusive techniques shall be reviewed and approved (or disapproved) by the Committee.
  3. Plans sent to the BTP Committee for review shall include:
    - a. Results of assessments to rule out relevant physical, medical and environmental causes of the problem behavior.
    - b. A functional assessment.
    - c. Results from 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.
    - d. Evidence of kinds of behavioral supports or interventions, including amount, scope and duration that have been attempted but proven unsuccessful in reducing/eliminating the behaviors.
    - e. Evidence of continued efforts
    - f. References to the literature should be included in the btp, and where the intervention has limited or no support, why the plan is the best option available.
    - g. The plan for monitoring and staff training to assure consistent implementation and documentation of the interventions.
- I. The PIHP shall establish a Behavior Treatment Plan Oversight Committee.
1. The Committee membership shall include:
    - a. The PIHP Medical Director (*the Medical Director will sign off on the meeting minutes when attendance is not possible*)
    - b. Chairs (or designee) of the CMHSP Behavior Management Committees
    - c. A psychologist appointed by CMHA-CEI
    - d. A Recipient Rights Officer as an ad Hoc (non-voting) member.
    - e. Others as deemed appropriate  
(*If any of the members are unable to attend a scheduled meeting, the individual will be responsible for reviewing the meeting minutes so he/she is aware of what occurred during the meeting*)
  2. The PIHP Behavior Treatment Plan Committee shall:
    - a. Meet at least quarterly or more frequently if needed.
    - b. Shall review data submitted by each CMHSP Behavior Treatment Committee including:
      - i. Number of current behavior treatment plans
      - ii. Number of plans that include intrusive and restrictive interventions
      - iii. Number of emergency physical management interventions that occurred during the reporting period.

- iv. Number of individuals that had repeated emergency physical management during the reporting period.
- v. The number of individuals with repeated emergency physical management that resulted in the development of a behavior treatment plan.
- c. Based on the review of the information above (section I.2.b.i-iv) the committee will do the following:
  - i. Make recommendations for staff training(s)
  - ii. Make recommendations for changes or additions to approved interventions.
  - iii. Provide case consultation/guidance to CMHSP Behavior Treatment Plan Committees as requested
  - iv. Ensure that each CMHSP is adhering to the Affiliation Procedure for Behavior Treatment Plan Review Committees.
  - v. Report analysis of submitted data to the Director of Affiliation Operations and Affiliation QI Workgroup

**V. APPLICATION:**

This procedure applies to all CMHAMM CMHSP's and providers.

**VI. MONITOR AND REVIEW:**

This procedure will be monitored by the Director of Affiliation Operations, with input from the Improving Practices Leadership Group and the PIHP Behavior Treatment Committee. The Director of Affiliation Operations reviews this policy annually, with input from the Improving Practices Leadership Group and the PIHP Behavior Treatment Committee. External review will include MDCH and CMS site visits.

**VII. RELATED POLICIES AND PROCEDURES:**

CMHAMM Policy          2.0          Clinical Policy