BARRY COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
POLICY AND PROCEDURE MANUAL

Policy: Behavior Treatment Plan Review Committee 6-C		Application: BCCMHA Staff & Providers
Reviewed 10/4/2023	Revised 10/4/2023	First Effective 8/25/1996

I. PURPOSE

To provide services that promotes recovery and wellness for each individual. All services shall be strength based, recovery focused and provided in the least restrictive manner.

To provide guidelines for the establishment and operation of a Behavior Treatment Plan Review Committee (BTPRC).

The BTPRC shall provide case consultation to clinicians and/or primary case holders. The BTPRC shall also monitor on a regular basis all Formal Behavior Plans and Positive Support Plans as prescribed by the MDHHS Technical Requirement for Behavior Treatment Plans.

The BTPRC shall assist the authors of the plans in making adjustments as deemed appropriate and necessary.

The BTPRC shall meet as often as necessary to accomplish these purposes.

The desired outcome of the BTPRC is to:
Promote and protect the rights and dignity of all individuals served by Barry County Community Mental Health Authority (BCCMHA).

1. Provide protection for individuals through an established review and appeals process.
2. Promote the use of least restrictive optimally effective treatment.
3. Assist staff by acting as a consultative resource committee.
4. Ensure that BCCMHA complies with the most recent version of the MDHHS Technical Requirement for Behavior Treatment Plans.

II. POLICY

It is the policy of BCCMHA to have a BTPRC, with its appointment, duties, and functions that are prescribed by the standards herein.

It is the policy of BCCMHA that behavioral treatment techniques are implemented in a manner that fully protects and promotes the rights of consumers. This shall include:

1. Not approving intervention that is used for the convenience of the provider.
2. Reasonable efforts to allow consumers to build skills necessary to be served in the least restricted setting possible.
3. Interventions are based on supporting data, evidence-based practices and accepted standard industry practices.

III. DEFINITIONS

Applied Behavior Analysis- The organized field of study which has as its objective an acquisition of knowledge about behavior using accepted principles of inquiry based on operant and respondent conditioning theory. It also refers to a set of techniques of modifying behavior toward socially meaningful ends based on these concepts of behavior. Although this field of study is a recognized, sub-specialty in the psychology discipline, not all practitioners are psychologists, and such training may be acquired in a variety of disciplines.

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

Therapeutic Time-Out- "Time out" means a voluntary response to the therapeutic suggestion to a client to remove him or her from a stressful situation in order to prevent a potentially hazardous outcome.

Evidenced-Based Practice- The integration of the best research evidence with clinical expertise and client values, or clinical interventions or practices, for which there is consistent scientific evidence providing that they repeatedly produce specific, intended results.

Physical Management- A technique used by staff as an emergency intervention to restrict the movement of a client by continued direct physical contact in spite of the client's resistance in order to prevent him or her from physically harming themselves or others. Physical management shall only be used on an emergency basis when the situation places the client or others at imminent risk of serious physical harm. To ensure the safety of each client and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations. The term "physical management" does not include briefly holding a client in order to comfort him or her or to demonstrate affection or holding his/her hand. Physical management involving prone immobilization of a client, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of a client in a prone (face down) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position.

Positive Behavior Support- A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other behaviors that place the client or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and system change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction and pica. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work and in the community.

Restraint- Use of physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a client's body as a means of controlling his/her physical activities in order to protect him/her or others from injury. Restraint differs from mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular part of such procedures. These mechanisms include, but are not limited to, body restraint during surgery and arm restraint during intravenous administration. Devices used to protect the client, such as bedrails, tabletop chairs, protective nets, helmets or the temporary use of halter-type or soft-chest restraints, and such mechanisms as orthopedic appliances, braces, wheelchairs or other appliances or devices used to posturally support the patient or assist him/her in obtaining and maintaining normative bodily functioning, are not considered restraint interventions. Persons who are diverted from jail or on parole or probation and required to wear a tether through court or other penal sanction, are not considered to be restrained under this policy.

Seclusion- Seclusion is generally defined as the temporary placement of a client 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 722.11 to 722.128.

Intrusive Anti-Psychotic/Psychotropic Medication- Anti-psychotic or psychotropic medication prescribed for the purpose of behavioral control, and which is not standard treatment for the person's diagnoses.

Program Plans Requiring Special Consent- 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 or drug when it is used 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.

Restrictive Techniques- Those techniques which, when implemented, will result in the limitation of the client's rights as specified in the 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: limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Techniques that accomplish restriction, intrusion, or painful stimulation; although called by another name; and techniques which are insufficiently documented in the established literature related to behavior management. ("Insufficient" means, in the best judgment of the program author, there are too few references in commonly available literature. A rough standard entails whether the technique is familiar to appropriately trained colleagues.)

Special Consent- Special consent means obtaining the prior written approval of the client, or the legal guardian, specific to the use of a particular treatment approach, which would otherwise entail violating the client's rights, even though general consent to treatment may have been obtained. For further information regarding "Consent," refer to the Recipient Rights and Informed Consent Policies.

Expedited Plan Review- Expedited means the plan is reviewed and approved in a short time frame such as 24-48 hours.

PROHIBITED BEHAVIOR MANAGEMENT TECHNIQUES

Aversive Techniques- Those techniques that require the deliberate infliction of painful stimulation (or stimuli which would be painful to the average person) to achieve their effectiveness. Examples of such techniques include electrical shock, slapping, use of mouthwash or other noxious substance to consequent 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 consequential target behavior. Michigan Department of Health and Human Services prohibits aversive techniques without the prior review and approval by DHHS.

IV. STANDARDS

The treatment plan identifies restrictions or limitations of the client's rights and includes documentation describing attempts to avoid such restrictions as well as what action will be taken as part of the plan to decrease or eliminate the need for the restrictions in the future.

Restrictions, limitations, or any intrusive behavior treatment techniques are reviewed by the BTPRC with specific knowledge, training, and expertise in applied behavioral analysis.

The following timeframes will be followed to facilitate the timely completion of behavior plans and their review:

	Time Frame
Report of Behavioral Issue:	30-day baseline
Behavior Plan Development:	2 weeks and/or prior to residential placement, whichever is earlier.
Behavior Plan Review:	90 days or more frequently as needed.
Expedited/Emergent Review:	24-48 hours after request.
Positive Support Plan:	90 days or more frequently as needed.

The BTPRC will be responsible for reviewing and approving all nonviolent crisis intervention techniques prior to the agency's utilization of the techniques. See the BTPRC Form Packet for the Approved Nonviolent Crisis Intervention Techniques document. Approved techniques will be considered an attachment of this policy and updated as often as necessary and will be included in the BTPRC Form Packet. The BTPRC will be responsible for reviewing and approving (or disapproving) all behavior treatment plans prior to the client and/or their guardian's signature and

implementation of the plan and as expeditiously as possible. The behavior plan is to be fully established prior to any residential placement. Review and approval are required for those behavior treatment plans generated by external providers. During the review process, the BTPRC will ensure that the approved behavior plan is based on a comprehensive assessment of the behavioral needs of the individual. Behavior treatment plans will be designed to reduce maladaptive behaviors, to maximize positive behavior and self-control, or to restore normalized psychological functioning, reality oriented, and emotional adjustment, thus enabling the individual to function more appropriately in interpersonal and social relationships. The committee will ask the committee member who has prepared a behavior treatment plan to be reviewed by the committee to recuse themselves from the final decision-making. If an independent agency provider creates or modifies a Formal Behavior Plan or Positive Support Plan, a section of the plan needs to detail prior use/trial of positive behavior supports/interventions, show the functional analysis was done and results of such, and reporting mechanisms for Formal Behavior Plans to include both full narrative or interventions and numerical data. If the independent agency provider fails to update a Formal Behavior Plan or Positive Supports Plan and obtain BCCMHA BTPRC approval for more than 30-days post expiration of previous plan date, the BTPRC will be responsible for creating and training staff/supports to the plan until the contract is resolved for the preferred functional analysis form. See the BTPRC Form Packet for an example of the preferred behavior observation procedure and forms.

The BTPRC shall consist of at least three clinical staff persons. At least one committee member should be a fully licensed or limited licensed psychologist with specific experience in applied behavior analysis; a licensed psychiatrist/physician; and another committee member must be a social worker. The Recipient Rights Officer shall participate on the committee as ex-officio, non-voting member in order to provide consultation and technical assistance. A Certified Peer Support Specialist shall participate with the committee as an expert in person-centered planning and experience with the public mental health system in the capacity of an ex-officio, non-voting member, when requested by and with consent of the individual whose behavior treatment plan is being reviewed.

The BTPRC and the committee chairperson shall be appointed by the agency for a term of not more than two (2) years. Members may be re-appointed to consecutive terms. For a detailed outline of member responsibilities, see the attachment "Behavior Treatment Committee – Individual Roles and Responsibilities" within the BTPRC Forms Packet in the Master Forms Book of the BTPRC Chairperson.

The functions of the BTPRC will be:

1. Review and approve (or disapprove) all behavior treatment plans in light of current research and prevailing standards of practice, the generalized use of token economies if the contingent removal of tokens is a planned part of the program, and those techniques requiring special consent by the client. Such reviews shall be completed as expeditiously as possible.
2. Determine whether analysis of the causes of behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and where neither has occurred, disapprove any proposed plan.

3. Review and approve or disapprove all program plans which involve the use of psychotropic medications applied for behavior control purposes and where the target behavior is not due to an active psychotic process.
4. Refer for MDHHS review and approval or disapproval, any behavior treatment plan as directed by regulation and technical requirements. See BTPRC Forms Packet. For those plans requiring MDHHS approval, endorsement must be obtained prior to the implementation of the plan. MDHHS will respond to usual requests within 30 days and urgent requests within 24 hours. For each MDHHS approved plan, set and document a statement to re-examine the continuing need for the approved procedures. This review shall occur at least annually.
5. For each MDHHS approved plan, set and document a date to re-examine the continuing need for approved procedures at least monthly from the date of the last review or more frequently if clinically indicated. For each BCCMHA approved plan, set and document a date to re-examine the continuing need for approved procedures at least quarterly from the date of the last review or more frequently if clinically indicated. This review is to coordinate with the review date(s) established in the behavior plan. The more intrusive or restrictive the intervention, or the more frequently they are applied, the more often the entire behavior plan should be reviewed by the committee.
6. The committee shall ask that a committee member who has prepared a behavior plan to be reviewed by the committee recuse himself or herself from the final decision-making.
7. The committee shall be scheduled to meet at least once per month, or more often as needed, and operate under the chairperson appointed by the Executive Director.
8. A written copy of all meeting minutes will be kept by the BTPRC chairperson and individual documentation of committee consultation recommendations will be entered into the client's medical record. See the BTPRC Forms Packet.
9. Provide decisions, in writing, to the responsible staff person with an indication of appropriate appeal process to the Executive Director in the event of continuing dispute.
10. Advise and recommend to the Executive Director the need for specific training in behavior modification for staff.
11. Listen to complaints from clients/guardians regarding the BTPRC. A written complaint form is contained in the booklet entitled, "Your Rights in Mental Health" along with instructions for completing the complaint form, the phone number of the Recipient Rights Officer, and the phone number and address of the Office of Recipient Rights for the Department of Health and Human Services in Lansing.
12. At its discretion, review other behavior modification programs not developed by BCCMHA staff if such reviews are consistent with the agency's needs and approved in advance by the Interdisciplinary Team.
13. Case consultation is available at the request of the client, staff, or any advocate on the behalf of the client when treatment circumstances create potential risk for the client (i.e., problems with diagnosis, unimproved outcomes, adverse reactions to treatment, or when person-centered desires are likely to result in a risk to the individual's health and safety).
14. The BTPRC will approve and review proposed behavior treatment plans. Requests for review or consultation may be made to the BTPRC by the primary case holder through the chairperson or any other committee member. See the BTPRC Forms Packet.

15. Ensure that the Behavior Treatment Plan is scanned into the medical record and a copy is forwarded to contractual providers, where appropriate. The primary case holder/author of the behavior plan will be responsible for conducting the face to face or video conference (meeting HIPAA Hi-TECH STANDARDS) training pertinent to the behavior plan with providers and their staff. The Behavior Plan is to be fully established and trained prior to any residential placement.
16. Review and discuss the use of any and all restraint or seclusion by looking at the incident, its antecedents, and the reason for seclusion or restraint, the client's reaction to the intervention, and actions that could make the future use of seclusion or restraint unnecessary. Whenever possible, the client and/or guardian will be present for this review. Restraint and seclusion are prohibited by policy in all service settings except licensed psychiatric hospitals (LPH) and child caring institutions (CCI). (See Restraint and Seclusion Policy).
17. The BTPRC will review and recommend modifications to the clinician for the client's person-centered plan of service to facilitate the reduction of the use of restraints in cases where restraints are used repeatedly.
18. Review, revise and approve the Behavior Plan. The case holder will assign a Goal number and attach it to the person-centered plan of service. See the BTPRC Forms Packet. The behavior plan is considered an element of the client's person-centered plan of service/treatment plan.
19. Utilize the meeting agenda and minute's format and summary of minutes' form at each BTPRC meeting. Appropriate meeting minutes' documentation will be uploaded into the Electronic Health Record (EHR).
    See the BTPRC Forms packet.
20. Collect the data related to indicators, evaluation, findings, action taken, and recommendations and make a report to the Quality Improvement Committee and the Executive Director on a quarterly basis.
21. Annually track the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each client receiving the intervention, as well as:
    a. Date and number of interventions used;
    b. Behaviors that initiated the technique;
    c. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention;
    d. Attempts to use positive behavioral supports;
    e. Behaviors that resulted in termination of the interventions;
    f. Length of time for each intervention. See the BTPRC Forms Packet.
22. Physical management, permitted for intervention in emergencies only, is considered a sentinel event that must be reported to DHHS on a quarterly basis.
23. Refer any unresolved issues or identified areas for improvement to the Quality Improvement Committee and/or Management Team.

<u>BEHAVIOR TREATMENT PLAN STANDARDS</u>

The person-centered planning process used in the development of an individualized written plan of service will identify when a behavior management or behavior 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 behavioral support and interventions, to change the behavior. Prior written consent must be given by the client or his /her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor.

The following items shall accompany behavior treatment plans that are forwarded to the BTPRC for review:

1. Results of assessments performed to rule out relevant physical, medical, and environmental causes of the problem behavior.
2. A functional assessment performed by qualified staff.
3. Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to behavior management at high risk for death, injury, or trauma.
4. Evidence of the kind of positive behavioral supports or interventions, including their amount, scope, and duration that have been attempted to ameliorate the behavior and have proven to be unsuccessful.
5. Evidence of continued efforts to find other options.
6. Previewed literature or practice guidelines that support the proposed intervention.
7. 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.
8. The plan for monitoring and staff training to ensure consistent implementation and documentation of the intervention(s).

V. PROCEDURE

BEHAVIOR TREATMENT PLAN COMMITTEE REQUEST

Known client is presenting behaviors which are:

1. Harmful to self
2. Harmful to others
3. Destructs property resulting in police/emergency room contact
4. Restricts the person from functioning safely in a less restrictive environment.

The primary worker will present relevant information gathered through contact with client, family, and/or significant others. Based upon consultation, a referral form will be completed and forwarded to the BTPRC Chair and/or their designee.

Assigned BTPRC clinician collects information and designs a behavior plan or positive supports plan, including for clients who receive psychotropic medications applied for behavior control purposes and where the target behavior is not due to an active psychotic process. See the BTPRC Form Packet.

If the assigned BTPRC clinician completes the Formal Behavior Plan, this plan is presented to the BTPRC for review and approval. The clinician must submit the Behavior Plan Referral Form with the proposed plan. See the BTPRC Form Packet.

BTPRC will review and monitor Formal Behavior Plans at a minimum of once every three months.

Assigned BTPRC clinician will be responsible for the behavior plan and any corresponding case note.

Assigned BTPRC clinician will meet with the client at a necessary frequency to adequately monitor process for Formal Behavior Plans.

The author of the BTP will be responsible for conducting the training pertinent to the behavior plan face to face or video conference (meeting HIPAA HI-TECH standards) with provider and staff. BTPRC Chairperson can assign another BTPRC clinician to conduct pertinent training to the behavior plan as needed.

The committee shall have an alternate member with the power to approve expedited/emergency plans. In cases where the designated behavior plan author and committee chair is the same BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 6-C Page 9 person, this alternate member will act in the capacity of the chair to receive, review, and approve expedited/emergency plans to avoid real or perceived conflicts from the author approving their own plan. This alternate will also fill in if the committee chair is unavailable at the time an expedited/emergency plan is requested. The alternate will follow the same process the Chair would follow, including working with the ORR

BEHAVIOR TREATMENT PLAN COMMITTEE DISCHARGE

The committee will make a recommendation for termination when the client has obtained the objective parameters of the goal (specifically the behavior plan), the client moves out of specialized level of care, the client has been discharged from the agency or the client becomes deceased.

Assigned BTPRC clinician will be responsible for filling out the BTPRC Termination Form. See the BTPRC Forms Packet.

Client/guardian may request to have their behavior plan terminated at any time. If this request is made, then either the assigned BTPRC clinician or case holder will fill out the BTPRC Termination Form.

Any client receiving psychotropic medication from BCCMHA psychiatrist to address behavior concerns cannot be terminated until psychotropic medications for behavior control are no longer prescribed. These clients will have their behavior plan monitored until the discontinuation of medication. At that time the client's assigned BTPRC clinician or case manager will complete a termination form.

REFERENCES AND LEGAL AUTHORITY

The Michigan Mental Health Code

MCL 330.1712
MCL 330.1740
MCL 330.1742

CARF
SWMBH
Technical Requirement for Behavior Treatment Plan Review Committees
DHHS Administrative Rule 330.7199(2)(g)
Empirically Validated Treatments/Evidence Based Practice Review
Behavior Management Review Sheet

ATTACHMENTS
Behavioral Treatment Plan Review Committee Attachments.pdf

APPROVED BY:

Richard Thiemkey — Date
Executive Director