BARRY COUNTY COMMUNITY MENTAL HEALTH AUTHORITY
POLICY AND PROCEDURE MANUAL

Policy: 6-C Behavior Treatment Plan Review Committee	Application: BCCMHA Staff and Providers
Approved: Richard S. Thiemkey, M.A. Richard S. Thiemkey, M.A. (Apr 16, 2025 08:54 EDT) Richard Thiemkey, MA Executive Director	

Reviewed	Revised	First Effective
2/26/2025	2/26/2025	8/25/1996

PURPOSE
To provide services that promote 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 monitor on a regular basis Behavior Treatment Plans as prescribed by the MDHHS Technical Requirement for Behavior Treatment Plans. The BTPRC shall also provide case consultation to clinicians and/or primary case holders.

BTPRC shall assist the authors of the plans in adjusting as deemed appropriate and necessary.

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

POLICY
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 the 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.

It is the policy of MDHHS that all publicly supported mental health agencies shall use a specially constituted committee, often referred to as a "behavior treatment plan review committee." In accordance, BCCMHA is to have a behavior treatment plan review committee, 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. Review and approval (or disapproval) of behavior treatment plans that purpose to use restrictive or intrusive interventions.
2. Not approving an intervention that is used for the convenience of the provider.
3. Reasonable efforts to allow consumers to build skills necessary to be served in the least restricted setting possible.

4. Interventions are based on supporting data, evidence-based practices and accepted standard industry practices.

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs for behavior control purposes for persons with an intellectual developmental disability (IDD) diagnosis shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC).

Any limitations of the recipient's rights, any intrusive treatment techniques, or any use of psychoactive drugs where the target behavior is due to active symptoms of a substantiated serious mental illness (SMI), or serious emotional disturbance (SED) as defined in Sec. 100d of PA 258 of 1974 does not require review and approval by the BTPRC.

DEFINITIONS

Anatomical Support

Body positioning or physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.

Applied Behavior Analysis-

A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual 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 combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Therapeutic De-Escalation-

An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient 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 himself or herself 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 recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: 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. To ensure the safety of each consumer and staff, each

agency shall designate emergency physical management techniques to be utilized during emergency situations.

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 combines valued outcomes, behavioral, 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 physical or mechanical devices 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 postural 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 sanctions, are not considered to be restrained under this policy.

Seclusion-

The temporary placement of a recipient in a room alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital 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.

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 an 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 or control an individual's behavior or restrict the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the BTPRC.

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. The Michigan Department of Health and Human Services prohibits aversive techniques without prior review and approval by MDHHS.

Behavior Treatment Plan Review Committee 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:

TIMFRAME
Report of Behavioral Issue: 30-day baseline with behavior data
Functional Behavior Assess: Within 4 weeks of due date.
Behavior Plan Development: 2 weeks prior to PCP meeting
Behavior Plan Review: 90 days or more frequently as needed.
Expedited Review: Reviewed within 2 business days by chair. (see Expedited Review section below)

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.

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 that lead to imminent harm to self or others, imminent trauma, or imminent death. 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 Behavior Treatment 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 Behavior Treatment Plans to include both full narrative or interventions and numerical data.

All limitations on the recipient's rights shall be justified, time-limited, and clearly documented in the Individual Plan of Service (IPOS). Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what systematic actions will be taken as part of the IPOS to ameliorate (improve) or eliminate the need for the limitations on recipient rights in the future.
Please reference the Home and Community Based Services (HCBS) chapter in the Medicaid Provider Manual for additional IPOS documentation requirements related to limitations.

PTB by External Provider:
Review and approval are required for those behavior treatment plans generated by external providers. If the independent agency provider fails to update a Formal Behavior 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.

<u>BTPRC Membership</u>
The BTPRC shall be comprised of at least three (3) individuals, one (1) of whom shall be a licensed behavior analyst, and/or licensed psychologist, if the behavior analysis services provided by the psychologist are within their education, training, and experience; and at least one member shall be a physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the BTPRC as ex-officio, non-voting member to provide consultation and technical assistance to the BTPRC.

The BTPRC and the committee chairperson shall be appointed by the Executive Director 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."

The functions of the BTPRC will be:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, seclusion, or restraint in a setting where it is prohibited by law or regulations. [link to Restrain/seclusion policy]

2. Determine whether causal analysis has been performed; whether positive behavioral supports and interventions have been adequately pursued; and where neither has occurred, disapprove any proposed plan.
3. Expeditiously review, in light of current peer-reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize limiting or intrusive techniques [see definitions].
4. For each approved BTP, set and document a date to re-examine the continuing need for approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition or when the individual requests the review as determined through the person-centered planning (PCP) process. BTPs with limiting or intrusive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of limiting or intrusive interventions to be reviewed more often than the minimal quarterly review, if deemed necessary. [link to PCP IPOS policy]
5. Assure that a causal analysis has ruled out any known medical, psychological, or other factors that the individual has, which might put him/her at a high risk of death, injury, or trauma if subjected to limiting or intrusive techniques.
6. Once a decision to approve a BTP has been made by the BTPRC and consent has been obtained from the individual, the legal guardian, the parent of a minor or a designated patient advocate, the BTP becomes part of the individual's written IPOS. The individual, legal guardian, parent of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the plan. The only exception for consent is when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
7. On a quarterly basis track and analyze the use of all physical management, restraint, seclusion, and involvement of law enforcement for emergencies as well as:
   i) Dates and numbers of interventions used.
   ii) The settings (e.g., individual's home or work) where behaviors and interventions occurred.
   iii) Observations about any events, settings, or factors that may have caused the behavior.
   iv) Behaviors that initiated the techniques.
   v) Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
   vi) Description of positive behavior supports used.
   vii) Behaviors that resulted in termination of the interventions.
   viii) Length of time of each intervention.
   ix) Staff development and training and supervisory guidance to reduce the use of these interventions.
   x) Review and modification or development, if needed, of the individual's BTP.

1. If it is determined through assessment and evaluation that an individual may benefit from an individualized BTP for the purpose of treating, managing, controlling, or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop a BTP that meets the following criteria:

a. Employs positive behavior supports and interventions using applied behavior analysis (ABA) or other evidence-based practices, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches. Per MCL 333.18253 (the public health code) an individual shall not engage in the practice of applied behavior analysis or practice as an assistant behavior analyst unless licensed or otherwise authorized under this article.

b. Considers other kinds of behavior treatment interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions if positive behavior supports and interventions are documented to be unsuccessful.

c. As a last resort, when there is documented evidence that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes interventions that place limitations on the individual's rights, intrusive treatment techniques or the use of psychoactive drugs. These interventions, described herein, shall be reviewed, and approved by the Behavior Treatment Plan Review Committee (BTPRC) prior to implementation.

2. 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 functional behavior assessments as defined in this policy have been conducted to rule out physical, medical, or environmental causes of the target behavior. If any limitations on rights or intrusive techniques are utilized there is documented evidence that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

3. Behavior Treatment Plans must be developed through the person-centered planning process and written consent must be given by the individual, or their guardian, on their behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes limiting or intrusive interventions. Behavior Treatment Plans are not effective or ethical if developed without consent or understanding of the participant.
4. The use of physical management, aversive techniques, restraint, seclusion or requesting involvement of law enforcement are prohibited from being included in the BTP and shall be disapproved by the BTPRC. Although emergency interventions are prohibited from inclusion as a component or step in any BTP, the BTP may note 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. [AR 7243(11)(i)]
5. Utilization of physical management, restraint, seclusion or requesting law enforcement in an emergency may be evidence of treatment/supports failure. Should use occur more than three (3) times within a 30-day period, the individual's written IPOS must be revisited through the person-centered planning process and modified accordingly, if needed.
6. Behavior Treatment Plans that are forwarded to the BTPRC for review shall be accompanied by:
a. Results of assessments performed to rule out relevant physical, medical, and environmental causes of the challenging behavior.
b. A functional behavior assessment as defined in this policy.
c. Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to limiting or intrusive techniques at high risk of death, injury, or trauma.

d. Documented evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate (improve) the behavior within the last 12 months, and have proved to be unsuccessful.
e. Documented evidence of continued efforts to find other options.
f. Practice guidelines that support the proposed use of limiting or intrusive techniques.
g. References to peer reviewed literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the BTP is the best option available. Citing of common procedures that are well researched and utilized within most BTPs is not required.
h. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s). The BTP must include who will provide the training and how it will be monitored for fidelity and modifications if needed.
7) Physical management, restraint, seclusion, and requests for involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards and must be evaluated by the PIHPs QAPIP or the CMHSPs QIP, and be available for MDHHS review. Any injury or death that occurs from the use of any BTP, physical management, restraint or seclusion is considered a sentinel event.

Expedited Reviews of Proposed Behavior Treatment Plans and Consultations
Expedited plan reviews may be requested when, based on data presented by the author of the plan requires immediate implementation. The Committee Chair may receive, review, and approve such plans on behalf of the Committee. The ORR must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. As with regular BTP reviews, the ORR will not vote on, or approve, any expedited plan. The Committee Chair or the designee will review and approve or disapprove the behavior plan within 48 hours of receiving expedited review request.
Upon approval by committee chair (or designee if the Committee Chair wrote the plan) and after consultation with ORR, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

PROCEDURES
Procedure for BTPRC Request/Consult/Annual Redetermination
A. Clients presenting behaviors which are currently 1) seriously harmful to self, 2) seriously harmful to others, 3) imminent threat of death 4) actively causing trauma maybe referred to BTPRC for case consultation.
B. The primary case holder will request consultation from BTPRC Chairperson to present relevant information gathered through contact with client, family, and/or significant others. BTPRC will determine if further assessment is needed.
C. If further assessment is needed, BTPRC clinician will conduct a Functional Behavior Assessment, which includes analyzing all behavioral data presented, interview with client and/or care givers, rule out of medical, physical or environmental factors and presenting findings of the assessment to BTPRC members for consideration.
D. If BTPRC members vote that a Behavior Treatment Plan is needed, the assigned BTPRC clinician completes the Behavior Treatment Plan.
G. BTPRC Clinician will present the Behavior Treatment Plan to BTPRC for review and approval. A formal roll call vote will be taken to approve or disprove the plan.

H. BTPRC Clinician will obtain voting BTPRC member signatures. BTPRC Clinician (or designee) will obtain client and/or guardian written signature.
I. The BTPRC Chairperson or designee will complete minutes for each individual presented.
J. The Chairperson will coordinate with Primary Case holders to schedule in person training with any appropriate direct or external providers. Documentation of training must be completed and kept in the client file.
A. Any Behavior Treatment Plans that include a modification of HCBS Final Rule will also require the Primary Case holder to amend the IPOS.
K. Only after all of the steps above have been completed can the BTP be implemented.
L. BTPRC will review and monitor the Behavior Treatment Plans at a minimum of once every three months, and more if deemed necessary by the committee.
1. For individuals monitored through BTPRC, an FBA will be completed annually to ensure that the need for a BTP remains.

Procedure for BTPRC Monitoring

G. Providers will provide data as outlined in the IPOS and contract. BTPRC or designee will coordinate with the provider to collect data, as needed. Failure for providers to provide data on an ongoing basis will be referred to the Contract Manager. BTPRC Clinician will review and analyze data collected.
H. Client's Case holder or designee will monitor the plan and present behavior data related to client at BTPRC meetings where case is discussed. BTPRC will review any restrictions to ensure that they continue to be appropriate and remain least restrictive.
I. All cases will be reviewed minimally every three months, and more if it is determined by BTPRC to be necessary.

Procedure for BTPRC Discharge

A. The committee will make a recommendation for termination when the client is no longer displaying identified behaviors that present of imminent risk for death, injury or trauma as outlined in the Technical Requirements or the client has been discharged from the agency, or the client becomes deceased.

B. Client/guardian may request to have their behavior plan terminated at any time. If this request is made, the case holder will notify BTPRC at the next meeting.

REFERENCE 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
MDHHS 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
Behavior Treatment Committee – Individual Roles and Responsibilities.
HCBS updates 2024