Chapter:	Section:	Subject:
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CHAPTER: Board Services and Program Administration		
SECTION: Behavior Treatment Committee		
SUBJECT: General Policy		
Administrative Approval:	Date of Governing Board Action: 2/20/96	Page 1 of 14

I. **PURPOSE:** To establish policies and procedures for intervening with an individual receiving public mental health services who exhibits seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm. To establish policy and procedures for the approval, review and use of behavior treatment/modification procedures.

II. **APPLICATION:** All programs and services directly operated by or contracted with West Michigan Community Mental Health.

III. **REQUIRED BY:** Michigan Department of Health and Human Services (MDHHS) Administrative Rules that pertain to behavior treatment practices. The Michigan Mental Health Code of 1996, as revised. Accrediting bodies. Michigan Department of Health and Human Services/CMHSP Managed Mental Health Supports and Services Contract FY 15 Attachment C.6.8.3.1

IV. **DEFINITIONS:**

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.**

Consent: A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Functional Behavioral Assessment (FBA): An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior plan. The focus of an FBA is to identify social, affective, environmental, and trauma-

based factors or events that initiate, sustain, or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan. The assessment is to include history of physical, sexual and emotional abuse, neglect, trauma and exposure to violence.

Emergency Interventions: There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.

Imminent Risk: An event/action that is about to occur that will likely result in the potential harm to self or others.

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. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her 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. To ensure the safety of each individual 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 an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it IS NOT physical management if the individual stops the behavior without resistance.

- When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

Physical management involving prone immobilization of an individual, 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 an individual 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 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 support 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, 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.

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

Proactive Strategies in a Culture of Gentleness: Strategies within a Positive Behavior Support Plan used to prevent seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm from occurring, or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include: unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings. See the prevention guide for a full list of proactive strategies and definitions.

Reactive Strategies in a Culture of Gentleness: Strategies within a Positive Behavior Support Plan used to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking.

Request for Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: The use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital. 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

- Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a behavior treatment plan which has been reviewed and approved by the Committee and received special consent from the individual or his/her legal representative.

- Medical restraint, i.e. the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

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

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

Time Out: A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.

V. **POLICY:** It is the policy of West Michigan Community Mental Health to establish a committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors

that place the individual or others at imminent risk of physical harm. The Behavioral Treatment Review Committee shall keep all its meeting minutes and clearly delineate the actions of the committee.

VI. **PROCEDURES:**

The following procedures are established to provide a planning, approval and review process for all behavior treatment/modification interventions/plans for WMCMH individuals meeting the criteria of this policy. WMCMH is committed to the concepts of normalization, person-centered planning, individuals residing in the least restrictive most normalizing community settings and use of non-aggressive psychological and physical interventions. The following procedures are not used by WMCMH: aversive techniques, seclusion, mechanical restraint, chemical restraint, or involuntary time out. Intrusive and restrictive techniques require BTR Committee review and approval.

A. COMMMITTEE STANDARDS

1. WMCMH shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions.

2. Members of the Behavioral Treatment Review Committee shall be appointed by West Michigan Community Mental Health's Executive Director per the guidelines of this policy.

    i. The Behavioral Treatment Review Committee (BTRC) shall be chaired by the Deputy Director of Clinical Services. The chairperson shall insure that Committee minutes are written which clearly delineates the action of the committee
    ii. The Committee will be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training; and at least one member shall be a licensed 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 Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee'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.

iii. The Committee shall meet as often as needed.

iv. Expedited Review of Proposed Behavior Treatment Plans: Plans can be expedited between meetings. The Committee Chair can obtain approval via email of members and record in the following month's minutes or the Committee Chair can approve independently in a crisis situation with discussion at the following meeting. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours. The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of the following AFC Licensing Rule:

> Adult Foster Care Licensing R 400.14309 Crisis intervention (1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. <u>If the individual requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the individual's designated representative and the responsible agency … to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan</u>.

Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Care Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, 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.

3. The Committee shall ask that a Committee member who has prepared a behavior treatment plan to be reviewed by the Committee to excuse themselves from the final decision-making.

4. The functions of the Committee shall be to:

   a. 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.
   b. 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].

c. Determine whether causal analysis of the causes of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
d. 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 that is 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 behavior 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. Assure that inquiry has been made about any known 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. If the person is part of the habilitation support waiver, and they have a behavior treatment plan that uses intrusive or restrictive techniques, then the Committee must review this plan every quarter.
e. Assure 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.
f. Arrange for an evaluation of the Committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates.
g. Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written Person Centered Plan. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written Person Centered Plan, 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, track and analyze the use of physical management for emergencies, the involvement of law enforcement and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
    1. Dates and numbers of interventions used.
    2. The settings (e.g., group home, gathering site) where behaviors and interventions occurred.
    3. Observations about any events, settings, or factors that may have triggered the behavior.
    4. Behaviors that initiated the techniques.
    5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
    6. Description of positive behavioral supports used.
    7. Behaviors that resulted in termination of the interventions.
    8. Length of time of each intervention
    9. Staff development and training and supervisory guidance to reduce the use of these interventions.
    10. Review and modification or development, if needed, of the individual's behavior plan.

    The data on the use of intrusive and restrictive techniques must be evaluated by the Performance Improvement Oversight Committee and must be available for MDHHS review. An analysis of the patterns, environments, and contributing factors is provided and reviewed. Physical management and/or 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. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

i. The Committee shall keep all its meeting minutes and clearly delineate the actions of the committee.

5. In addition, the Committee <u>may</u>:

    a. Advise and recommend to the agency the need for specific staff or home-specific training in a culture of gentleness, positive behavioral supports, and other individual-specific non-violent interventions.
    b. 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 or harm. 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.

c. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices
d. Provide specific case consultation as requested by professional staff of the agency.
e. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
f. Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

B. BEHAVIOR TREATMENT PLAN STANDARDS

1. The Person Centered Plan process used in the development of an individualized written plan of service will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral 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 supports and interventions, to prevent or address the behavior.

    a. 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 guardian on his/her 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 intrusive or restrictive interventions.
    b. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement 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 Committee.
    c. 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 Committee.
    d. Any intrusive or restrictive techniques are administered by staff who are trained and competent in the proper techniques identified in the formal behavior plan.

e. Emergency interventions are used as a last resort (and to prevent harm to self or others) and only after all other interventions outlined in the formal behavior plan have been exhausted.
f. Utilization of physical management 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. MDHHS Administrative Rules prohibit emergency interventions from inclusion 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.

2. The Care Manager will assess the individual's needs and will write a formal referral if the individual is actively engaging in behaviors of sufficient concern to warrant the consideration of a behavior treatment/modification intervention. This will be referred by the care manager to the behavioral psychologist. An authorization will be obtained for behavior treatment committee and for the assessment.

3. The Behavior Treatment Review Committee, utilizing the expertise of a clinical staff member or contractual consultant privileged/or deemed competent by WMCMH to practice the specialized therapy of behavior modification, shall as a "team" examine the data from the RCM, and mutually decide if the identified individual's behavior requires a formal behavior treatment/ modification intervention plan as a component of the individual's Person Centered Plan.

4. The Behavioral Psychologist will complete a behavioral assessment/analysis of the individual's challenging behavior.

5. Plans that are forwarded to the Committee for review shall be accompanied by the following:

   a. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   b. A functional behavioral assessment.
   c. 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.

d. 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.
e. Evidence of continued efforts to find other options.
f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
g. 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. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.
h. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).
i. Each plan that utilizes any restrictions or limitation of the individual's rights shall be reviewed and approved by the Behavior Treatment Committee. Any restriction or limitation shall be justified, time-limited, and clearly documented in the plan of service. The plan that utilized restrictive techniques shall specifically state what needs to occur for the restrictive techniques to be discontinued.

6. The individual, the individual's custodial parent, or guardian, may be invited by the care manager, to attend and participate in the committee meeting when it appears appropriate.

7. The Care Manager and psychologist responsible for writing the plan shall ensure that all WMCMH staff, contracted consultants and/or contracted providers involved with the implementation of formal behavioral plans have been trained as to the behavioral procedures, recording of behavioral data, emergency procedures including the methods to monitor the individual's vital signs during the application of a physical management procedure, required levels and periods of review. The Recipient Rights Officer provides consultation regarding plans rather than approve or not approve them so as to avoid potential conflict of interest. The psychologist responsible for writing and monitoring the behavioral plan shall ensure that all staff/persons responsible for implementing the behavioral plan and/or tracking the behavioral intervention data are adequately trained prior to the plan's implementation, and shall review the implementation of the procedures and data at least every 90 days and document his/her review in clinical case record.

8. The individual's assigned Care Manager/Care Supports Team shall review all behavior treatment/modification plans when reviewing the individual's response to his/her total service programming as specified in the Person Centered Plan. Please note if freedom of movement is restricted, this must be part of the Behavior Treatment Plan. If an individual is placed in a home that restricts the individual's freedom of movement, this must be part of the individual's Person Centered Plan.

9. The responsible care manager shall review all behavior treatment plans for his/her assigned individuals on at least monthly basis or more often as specified by the BTRC and document his/her review in the clinical case record.

VII. **SUPPORTING DOCUMENTS:**

Appendix 2-9-1A: Formal Behavior Program Plan (WMCMH Form #CD007)
Appendix 2-9-1B: MDHHS Technical requirement for Behavior Treatment Plan Review Committees Final: Revisions FY '14
Appendix 2-9-1C: Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness, June 27, 2011
Appendix 2-9-1D: Emergency Interventions Training Survey Summary of Results November 2011

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM

FORMAL BEHAVIOR PROGRAM PLAN

CUSTOMER NAME: _____ **CASE #:** _____

D.O.B.: _____ **CURRENTCMH PROGRAM(S):** _____

PCP DESIRED CHANGE: _____

PCP OUTCOME: _____

ID NUMBER: _____ **DATE:** _____ **PROGRAM DESIGNER:** _____

Plan Uses: ___Restrictive Techniques ___Intrusive Techniques ___Positive Behavioral Supports and Interventions

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1. BEHAVIORS TO BE CHANGED _____

_____

_____

_____

2. Assessment: (include baseline data, what was tried before, assessment of physical, medical or environmental causes of behavior and functional assessment, evidence of continued efforts to find options for addressing behaviors prior to plan request)

3. Review of the Literature include date of research: _____

4. GOAL OF PROGRAM: _____

_____

_____

_____

5. OBJECTIVE OF PROGRAM: _____

_____

_____

_____

6. TARGET BEHAVIOR DEFINITIONS: _____

7. PROCEDURE: _____

8. Review of medical, physical or psychological factors that might put the person at risk if subjected to intrusive or restrictive techniques:

9. DATA RECORDING: (include data sheet)

10. Plan for Training Caregivers:

11. Plan for Monitoring:

12. CRITERIA FOR PROGRAM REVIEW AND TERMINATION:

13. PERSON RESPONSIBLE FOR PLAN IMPLEMENTATION: How often to be monitored by Care Coordinator and psychologist

14. This plan does not include any of the following:
____Seclusion Restraint
____ Adversive Techniques
____ Physical Management

15. **GUARDIAN REVIEW:** I understand this program and ☐ approve ☐ do not approve of its implementation.

Guardian's Signature _____ Date _____

BEHAVIOR TREATMENT REVIEW COMMITTEE APPROVAL **DATE**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLAN IMPLEMENTATION DATE: _____

Date of next BTRC review

PLAN TERMINATION DATE: _____

REASON FOR TERMINATION: _____

_____

MDCH/CMHSP Managed Mental Health Supports and Services Contract FY 14
Attachment C6.8.3.1

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION
Technical Requirement
For Behavior Treatment Plan Review Committees
Revision FY'12

Application:

Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

Exception: State operated or licensed psychiatric hospitals or units when the individual's challenging behavior is due to an active substantiated Axis I diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or successor edition published by the American Psychiatric Association.

Preamble:

It is the expectation of the Michigan Department of Community Health (MDCH) that all public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all other non-emergent or continuing occurrences of these behaviors, the public mental health service agency will first conduct appropriate assessments and evaluations to rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.

MDCH will not tolerate violence perpetrated on the individuals served by the public mental health system in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used 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 an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R.330.7199[2]][g]) and that:

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or 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; or

- As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

MDCH requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code.

I. POLICY

It is the policy of MDCH that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here, with individuals served by the public mental health system who exhibit seriously aggressive, self injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards herein, including those for its appointment, duties, and functions.

II. DEFINITIONS

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**.

Consent: a written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Functional Behavioral Assessment (FBA): an approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan.

Emergency Interventions: There are only two emergency interventions approved by MDCH for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.

Imminent Risk: an event/action that is about to occur that will likely result in the potential harm to self or others.

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. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her 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. To ensure the safety of each consumer 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 an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it IS NOT physical management if the individual stops the behavior without resistance.
- When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

Physical management involving prone immobilization of an individual, 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 an individual 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 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 support 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, 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.

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

Proactive Strategies in a Culture of Gentleness: Strategies within a Positive Behavior Support Plan used to prevent seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm from occurring, or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include: unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings. See the [prevention guide] for a full list of proactive strategies and definitions.

Reactive Strategies in a Culture of Gentleness: Strategies within a Positive Behavior Support Plan used to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking. See the [prevention guide] for a full list of reactive strategies and definitions.

Request for Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when:** caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: The use of a physical or mechanical *device* to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital. 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

- Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a behavior treatment plan which has been reviewed and approved by the Committee and received special consent from the individual or his/her legal representative.

- Medical restraint, i.e. the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

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: 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. 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 written consent of the individual, the legal guardian, 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 individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

III. COMMITTEE STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCl 330.1 137, that receives public funds under contract with the CMHSP and does not have its own Committee must also have access to and use of the services of the CMHSP Committee regarding a behavior treatment plan for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the Committee to a contracted mental health service provider, the CMHSP must monitor that Committee to assure compliance with this Technical Requirement.

B. The Committee shall be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training: and at least one member shall be a licensed 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 Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee'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 Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms.

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:
Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.

The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of the following AFC Licensing Rule:

> Adult Foster Care Licensing R 400.14309 Crisis intervention
> (1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the [individual] requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the [individual's] designated representative and the responsible agency ... to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan. (Emphasis added)

Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, 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.

F. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee.

G. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision making.

H. The functions of the Committee shall be to:
1. 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.
2. 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].
3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
4. 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 that is 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 behavior 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.
5. Assure that inquiry has been made about any known 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.

6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody 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 behavior treatment plan. (MCl 330.1712 [2])

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   1. Dates and numbers of interventions used.
   2. The settings (e.g., individual's home or work) where behaviors and interventions occurred.
   3. Observations about any events, settings, or factors that may have triggered the behavior.
   4. Behaviors that initiated the techniques.
   5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
   6. Description of positive behavioral supports used.
   7. Behaviors that resulted in termination of the interventions.
   8. Length of time of each intervention.
   9. Staff development and training and supervisory guidance to reduce the use of these interventions.
   10. Review and modification or development, if needed, of the individual's behavior plan.

   The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDCH review. Physical management and/or 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. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

J. In addition, the Committee may:
   1. Advise and recommend to the agency the need for specific staff or home specific training in a culture of gentleness, positive behavioral supports, and other individual-specific non-violent interventions.
   2. 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 or harm.
   3. 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.
   4. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
   5. Provide specific case consultation as requested by professional staff of the agency.

6. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
7. Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

IV. 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 functional behavioral 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 supports and interventions, to prevent or address 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 guardian on his/her 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 intrusive or restrictive interventions.

C. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement 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 Committee.

   Utilization of physical management 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. MDCH and DHS Administrative Rules prohibit emergency interventions from inclusion 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 Committee.

E. Plans that are forwarded to the Committee for review shall be accompanied by:
   1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   2. A functional behavioral assessment.
   3. 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.
   4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
   5. Evidence of continued efforts to find other options.
   6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   7. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan is the best option available. Citing of common procedures that are well researched and utilized within

most behavior treatment plans is not required.

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

Legal References

1997 Federal Balanced Budget Act at42CFR 438.100
MCl 330.1712, Michigan Mental Health Code
MCl 330.1740, Michigan Mental Health Code
MCl 330.1742, Michigan Mental Health Code
MDCH Administrative Rule 700 1(I)
MDCH Administrative Rule7001(r)
Department of Community Health Administrative Rule 330.7199(2)(g)

Attachment 2-9-1C

MICHGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness

June 27, 2011

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I. Introduction

The Michigan Department of Community Health (MDCH) promotes the use of positive supports in a "culture of gentleness" as a means to interact with the people served in the public mental health system. People who exhibit behaviors that put themselves or others at risk of harm especially must be helped to feel safe and valued in the environments where they receive services. For such individuals, MDCH encourages the system to develop behavior plans that include positive behavior supports and non-restrictive and non-intrusive behavioral interventions. However, when the implementation of positive supports or a less restrictive behavior plan is not successful in keeping the individual safe, there may be a need to include more intrusive and/or restrictive measures. The Technical Requirement for Behavior Treatment Plan Review Committees (TR), which became effective October 1, 2007, was added as an attachment to the fiscal year (FY) 2008 contract between MDCH and Michigan's Pre-paid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs). The TR requires that Behavior Treatment Plans that include restrictive and/or intrusive techniques be submitted to the local Behavior Treatment Plan Review Committees (the Committees) for review and approval, and provides guidance to the Committees for reviewing and approving or disapproving these plans. The Committees are responsible for ensuring that a thorough assessment of needs has been conducted looking for how and what positive supports have been and will be used before intrusive or restrictive interventions are considered and approved.

This guide provides information and assistance to the Committees, behavior plan1 developers, program directors, providers, group home supervisors, and caregivers of adults and children in all settings. This informational document is intended to provide examples and definitions of prevention and positive behavior supports and techniques in a culture of gentleness and to encourage the use of these approaches before implementing intrusive or restrictive interventions outlined in a Behavior Treatment Plan to address challenging behaviors2. Although behavior plans have traditionally been used in working with individuals with developmental disabilities, these prevention and positive approaches have been proven to be effective with other populations. Therefore, this guide is intended to apply to adults and children with developmental disabilities, adults with serious mental illness, and children with serious emotional disturbance.

II. Prevention

The Michigan public mental health system has learned through various experiences of the last three years, including the Mt. Pleasant Center transition, Center for Positive Living Supports activities, and meeting with the Michigan Department of Human Services' Adult Foster Care Licensing Division, that having supportive and safe environments and taking certain preventive measures are the greatest deterrents to challenging behaviors, and the resulting need to employ intrusive and/or restrictive interventions. Thus, it is the responsibility of all entities to promote and model positive supports in a culture of gentleness for all people served by the public mental health system.

A. Feelings of Safety and Value

It is important that the culture of the person's home and other places where he/she receives public mental health services, as well as the organization(s) affiliated with those places, are supportive of, and safe for, him/her. Many of the people served by the public mental health

1 For purposes of this guide, "behavior plan" is a generic term for any plan that addresses challenging behaviors. This would include both a Positive Behavior Support Plan and a Behavior Treatment Plan.
2 The term "challenging behaviors" is used in this guide to describe seriously aggressive, self-injurious, or other behaviors that place the individual or others at imminent risk of harm.

system have suffered trauma, in many cases repeated, in the past. Their clinical records contain reports of abuse, neglect, sexual assault, over-medication, abandonment by family, and frequent moves among foster care settings, institutional settings, and jail. These adverse experiences have forced many of the people to be fearful of others and to develop "defense mechanisms" aimed at protecting themselves. When the fear and distrust are coupled with an individual's inability to verbally communicate, we often see challenging behaviors. When caregivers and professionals interpret these behaviors as manifestations of "disobedience" and "non-compliance" with "rules" and react with force, it can lead to more fear and distrust, and often cause the individual to be re-traumatized. It should be noted that in some instances, individuals who are part of loving and caring families may still, at times, exhibit challenging behaviors.

All individuals served by the public mental health system must feel valued, understood, and safe in the places where they are supported. Regardless of whether an individual lives in a place of his/her own or a licensed facility, it is his/her home and should be a safe haven. This place must be treated as the individual's home by all who may work there or who come to it. What happens in this place needs to center around what works for the person or people who live there, i.e., person-centered, not around the tasks that the caregivers need to complete on their shift, i.e., task-oriented, nor centered around maintaining compliance with "house rules."

A supportive and safe environment promotes helping the individual to establish and maintain meaningful relationships with caregivers in the home and people outside the home; supporting and assisting the individual to get involved in activities in the home and in the community that have value to him/her; shifting more choice and control to the individual; valuing and supporting caregivers; and providing continuous on-site support and training to home staff. Each of these areas will be further discussed in the pages that follow.

B. Establishment of Meaningful Relationships

Caregivers are in the position to help people create the foundations they need to be able to establish and maintain relationships. Relationships with others are crucial to a quality life and good mental and physical health, yet many of the individuals supported by the public mental health system, have few or no meaningful relationships. Good relationships are based on making individuals feel safe and unconditionally valued. Caregiver interactions, especially in the beginning stage of relationships or when the individual is feeling especially vulnerable, must focus on nurturing and valuing him/her. Once the foundation has been established, the circle of relationships can be more easily expanded.

C. Meaningful Activities

Individuals who have things to do during the day that are meaningful to them, in the home and out in the community, are less likely to exhibit the behaviors that result in the need for reactive interventions. In fact, there are many individuals who exhibit challenging behaviors at home, but exhibit none when they are out in the community. It is through a person's involvement in and completion of a task, game or routine that he/she can receive the positive affirmation, encouragement and support that leads to trusting others, feeling valued and gaining self-worth. Having meaningful activities also reduces boredom, both at home and in the community.

While it is important that each individual has the opportunity to choose the things he/she wants to do, he/she should also be assisted in performing the tasks that are part of everyone's life. These typical routines of daily life, and assisting the individual to perform them, should be the foci around which the operation of the home revolves, rather than a set

of tasks that need to be accomplished solely by caregivers while they are on their shift, such as meal preparation, cleaning, laundry, and grocery shopping.

Meaningful activities in the "community" are things that any person would do during his/her day, such as going to sporting events, plays or music events, volunteering, paying bills, going to the bank, buying a lottery ticket, going to the salon for a haircut, getting a membership at the gym, buying greeting cards at the store and mailing them at the post office to friends and family, picking up a newspaper at the same place every day, having coffee with a friend, and visiting a family member. The act of engaging in these activities of life brings with it not only multiple opportunities to make choices and to perform transactions that lead to self-confidence and self-worth, but also to interact with other human beings. Receiving a friendly welcome at the door of Meijer every week will be much more significant to the individual who goes there to buy a few personal items, than to the caregiver who ran to the store to pick up the items for him/her. Looking at all the goods available in the store, including colors, textures, funny pictures, sweet words, and even sounds, is also an activity in and of itself, and provides a low-risk opportunity to make a selection.

D. Opportunities for Making Choices

Every person has the right to choice and control in his/her own life. Arrangements that support Self-Determination give an individual true choice and control to self-direct his or her own life. As an individual has more and more frequent community activities in his/her life, he/she will have more and more opportunities to make choices. However, caution should be taken that individuals who are not used to having choice and control are not overwhelmed with too many choices or too many open-ended choices too soon. The more vulnerable the individual, the more consideration should be given for the level of support for their choice-making.

E. Identification of Precursors

Conducting a functional assessment of the precursors to challenging behaviors can serve to identify "triggers" that set off an action, process, or series of events and interactions that make individuals feel unsafe, insecure, anxious, panicked, or agitated. There is often a reason, situation, or person that is causing a particular reaction from the individual. In order to prevent such a reaction and promote a calm, safe, and positive environment, it is important to identify, then remove or reduce exposure to, the potential precursors that may initiate, sustain, or end a particular behavior.

The following are precursors that could contribute to a challenging behavior:

Transitions between Activities and/or Caregivers

It is possible that an individual may not like to do certain activities, such as family visits, going to bed, or taking a shower. Therefore, when he/she knows it is time for this activity, he/she may become frustrated. Similarly, the individual may not like or feel comfortable with a specific person living in the home, or a caregiver or other staff person working in the home. When he/she is around this person, he/she may exhibit a challenging behavior. There are also certain situations that could be a trigger for the individual, such as being isolated, feeling pressured, people being too close, people yelling, being in the dark, or people being too close.

Sensory Integration

Difficulties with sensory integration processing create anxiety in some people due to

over- or under-stimulation. It is important to have this assessed if it is suspected to be a precursor to challenging behavior. Sensory integration processing issues are often associated with individuals who have autism; however, they can also affect other individuals. People identified as having sensory integration processing issues should receive necessary interventions, many of which need to be included as part of their daily routines.

Physical Health

Chronic health conditions and acute episodes of illness can heighten sensitivity and trigger challenging behavior. An annual physical examination and a medical history record are important to identify and track conditions, and should be used as a basis for a care plan that calls for caregivers to pay attention to early signs that a condition is reoccurring or intensifying.

The medications individuals take can cause reactions, some paradoxical to the purpose of the medication. Some medications may make an individual feel "different" but have no physical signs, and the individual may communicate these subtle feelings through exhibiting a challenging behavior. Other individuals may be overmedicated and experience medication interactions.

Many individuals who exhibit challenging behaviors also receive psychiatric services. It is critical that psychiatrists are making recommendations regarding diagnosis and treatment on sound objective information.

Another type of "precursor" is the cues, or early warning signs, the individual gives that they are beginning to feel unsafe, insecure, anxious, or frustrated. By becoming sensitive to these cues, we can change our interactions to be more supportive and less demanding before the situation escalates into more dangerous behaviors. Some examples of these cues are restlessness, shortness of breath, pacing, sweating, shaking, rocking, crying, and clenching teeth.

There are numerous strategies that can be used to calm an individual when he/she shows signs of no longer feeling safe. Strategies will vary from person to person. Some individuals may prefer to talk to someone, including peers, family, or maybe staff. Others may want to lie down or listen to peaceful music or look at a magazine. Taking a walk or exercising may also help. It is important to remember to ask the individual what helps him/her calm down. Be creative, and if a strategy does not work, try something else.

F. Transition Planning

Transitions can be very stressful for individuals. Transitions include changing homes or jobs, changes in caregivers at shift change, or may be something as simple as getting up in the morning or ending one activity and beginning another.

Changes in Homes

Whether the individual is moving because of his/her choice or because of the decision of others, it is one of the biggest changes he/she will make in life. The public mental health system needs to become better at matching individuals with the places they will live, people who will live with them, and people who will support them, regardless whether he or she moves to a family home, own home, or group home. The CMHSP, provider, and home staff should have frank discussions about whether an individual would be successful in a particular home or conversely, whether the home can successfully

support the individual; develop together and implement a very detailed transition plan; make sure caregivers are trained and supported; and provide on-going on-site assistance and support to the home.

In-Home Transitions

Small transitions made on a daily basis can make a person feel anxious and insecure. Some examples of daily transitions include: getting out of bed in the morning, brushing teeth after breakfast, leaving for work/school, changing tasks at work/school, moving from one location to another at work/school, coming home from work/school, getting ready for dinner, and getting ready for bed. For those who have multiple caregivers, the change of shift can also be disconcerting.

It is important to make transitional events as predictable as possible and to be encouraging and less demanding during these times. Reviewing with the individual visual cues and/or schedules can also assist during transitions.

G. Caregiver Interactions

Interactions with individuals need to promote a sense of companionship, connectedness and community. Caregivers need to be very self-aware of how they are perceived by the individual they support. The vulnerabilities a person brings to an interaction determine how interactions are perceived. In some cases, a caregiver's presence alone can trigger memories of demands and trauma in the individual being supported. Caregivers need to be aware of what their body posture, facial expression, tone and volume of voice, and hand gestures communicate. Smiles and expressions of warmth are needed at all times. Words need to be soft, slow and uplifting. Touch needs to be respectful and purposeful in making the individual feel safe and valued.

H. Communication

Behavior is a form of communication. Behaviors identified as challenges are often expressions of unmet needs. Caregivers should not only identify the unmet need and try to meet it, but also attempt to teach the individual other ways to communicate his/her needs, such as needing to take a break, not feeling well, or needing affection. As with any attempt to build a skill, this can only be done successfully if the individual is taught by someone who truly understands and cares about him/her.

I. Staff Training and Support

Only the most skilled caregivers should be supporting individuals who have a history of challenging behavior. The CMHSP and provider need to assure that caregivers are properly trained to best support the individual. Using temporary or rotating/floating staff that has not been trained to support the specific individual should be avoided entirely. Caregivers should receive basic direct care staff training, training specific to the individual, transitional training, and knowledge of preventive strategies related to the issues that lead to the individual's anxiety or frustration. All home staff, provider staff, and CMHSP staff should be trained in approaches that support a culture of gentleness.

The provider needs to ensure that caregivers are valued and supported, but also have clear directions on what is expected of them. It is consistently reported across the state that direct caregivers who feel valued and supported by their supervisors, the provider, and the CMHSP are more satisfied with their jobs and are less likely to leave. Staff turnover can have devastating effects on the individuals they support. If the relationships were positive,

staff departure is another loss to the individual. The costs associated with turnover cannot be minimized either. Home staff should hold regular staff meetings that focus on support, improving morale, coaching and reinforcement of training, and problem-solving.

Direct caregivers, who view the place where they work as an individual's home, and perceive the individual as a peer, will be less likely to treat him/her as a less-valued person. Individuals who feel safe in the presence of caregivers, who feel valued, and who are receiving positive and undivided attention from caregivers are less likely to exhibit challenging behaviors. However, some caregivers may need to be coached and supported in making the transition from viewing their job as custodial and relating solely with other caregivers, to interacting and connecting with the people they serve. Helping to build and strengthen the relationships between individuals and caregivers should be a primary goal of managers and supervisors. Another goal should be clearly communicating expectations about caregiver behavior on the job (e.g., texting and taking personal calls need to be confined to staff break periods).

CMHSPs should provide on-going, on-site clinical, case management/supports coordination involvement and support to the home staff for situations that are challenging. Clinicians and case managers/supports coordinators need to be trained in positive behavioral support techniques, in addition to the providers and home staff. Clinical support staff should also commit to and have the skills to be able to work along-side the direct caregivers to assist in modeling, coaching and troubleshooting.

If there is potential (i.e., based on recent history) that a challenging behavior may occur, then there should be a written behavior plan for what home staff are to do. If the action caregivers are to take requires a behavior plan, then the plan should go to the setting with the individual; caregivers should be trained in the implementation of the plan; and the plan should be continually evaluated, modified and updated as needed. The CMHSP should provide ongoing and on-site support and mentoring to the provider and home staff as necessary to assist in the implementation of the behavior plan. Also, the provider should have leadership present during all waking shifts: a manager, assistant manager, a lead direct care worker, or a shift leader who has experience in implementing behavior plans that focus on helping the individual feel safe and valued. The home should also be cognizant of the organization of staff resources, and schedule new caregivers with more experienced caregivers.

III. Positive Behavior Support Plan

MDCH encourages the development of a Positive Behavior Support Plan that includes positive approaches to preventing and decreasing challenging behaviors, as well as focusing on improving the individual's quality of life. All behavior plans must be developed with the individual during the person-centered planning process.

The TR requires that the Behavior Treatment Plan Review Committee (the Committee) review any Behavior Treatment Plan that includes intrusive and/or restrictive techniques. However, it is suggested that all behavior plans developed by the CMHSP be reviewed by the Committee or by other available resources, such as clinical or interdisciplinary peer review or case consultation. Members of the Committee and other available resources provide valuable expertise that may assist the plan developer in improving the behavior plan.

A. Key Ingredients to an Effective Positive Behavior Support Plan

The following guidelines are useful to assist the plan developer in creating a Positive Behavior Support Plan:

1. Involving the individual in the development and implementation of the plan during the person-centered planning process allows him/her to achieve goals that he/she has chosen.
2. A functional behavioral assessment looking at the situational and motivational variables affecting the presence of a challenging behavior helps the person and everyone involved to understand why the behaviors occur and develop workable ways to achieve better alternatives.
3. Everyone who relates to the individual in any important way should receive training on how to participate in his/her plan.
4. Data collection and analysis of the plan will allow the individual to track his/her progress over time, as well as identify problems early.
5. Celebrate progress in meeting goals.

B. Positive Behavior Supports in a Culture of Gentleness

The MDCH preferred approach when addressing aggressive, self-injurious, or other challenging behaviors is to use Positive Behavior Support strategies within the framework of a Culture of Gentleness. Positive Behavior Support is a set of research-based strategies used to increase opportunities for an enhanced quality of life while decreasing challenging behaviors by teaching new skills and making needed changes in a person's environment (Association for Positive Behavioral Supports [APBS]). Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school or work, and in the community. Positive Behavior Supports include, but are not limited to, the following:

1. Provision of a sense of safety
2. Teaching the individual that engagement with others is good
3. Teaching the individual to value others and provide opportunities to establish meaningful relationships
4. Enhancement of the individual's sense of self-value
5. Assurance of consistency through structure
6. Provision of opportunities to express autonomy while receiving necessary supports
7. An environment that is conducive to optimal learning
8. Teaching skills that promote companionship, esteem building, problem solving and coping abilities
9. Community inclusion

C. Proactive Strategies in a Culture of Gentleness

Supporting individuals in a Culture of Gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. The following are some general strategies to consider when trying to prevent challenging behaviors from occurring in the first place, or for reducing their frequency, intensity, or duration:

1. Unconditional Valuing – through the actions (words, touch, eyes, presence) of the caregivers, the individual must feel that they are valued for who they are, not for what they have done or not done.
2. Precursor Behaviors – look for indicators that the individual is starting to feel unsafe or anxious and immediately drop demands and increase rewarding or positive interactions.
3. Environmental Management – items that could be distracting or used as weapons should be placed out of sight; how caregivers position themselves can prevent possible injury.

4. Stimulus Control - set up the materials for activities before the person arrives so as to ensure success through the consideration of factors such as the arrangement and control of materials, concreteness of the task, teaching methods, location, etc.
5. Errorless Learning (Chaining) - break learning skills into a sequence which facilitates their acquisition, and provide adequate support in order to avoid errors (so that structured tasks can serve as vehicles to teach that the interaction is more important than the task itself).
6. Teach Quietly - initially using minimal verbal instruction maximizes the power of verbal reward, and prevents on-task confusion. Gradually use more language as the strength of the relationship allows the ability to "stretch" the individual.
7. Shaping and Fading - use the caregiver's initial intense presence, necessary support and valuing teaching as a way to ensure as much as possible the person's on-task attention (shaping), and then as rapidly as possible remove the external support so that the person will remain on-task and be able to receive sufficient reward from the task itself (fading).
8. Assistance (Prompting) - initiate learning with a sufficiently high degree of assistance to ensure success and systematically and rapidly decreasing the degree of assistance, but ready at any given point in time to offer higher degrees of assistance as needed for the purpose of redirection or valuing.
9. Using the Task as a Vehicle, Not an End in Itself – each part of the day needs structuring so that there are opportunities to create valuing interactions - we cannot wait for these opportunities to present themselves; the task of learning is secondary to teaching that interactions are rewarding in and of themselves.
10. Redirection - the redirection of an individual to a more positive interaction/activity through minimal verbal or gestural guidance; redirecting to a break or away from anxiety-provoking situations; if capable, redirecting to utilize previously learned coping skills.
11. Reinforced Practice – providing many opportunities to practice and receive validation for performing newly learned behavior in order to ensure its retention.
12. Validating Feelings – verbally acknowledging what the individual may be feeling
13. Reinterpreting or Reframing Antecedent Events – helping the individual get a different perspective on the precipitating event.

D. Reactive Strategies in a Culture of Gentleness

Positive Behavior Support Plans should give caregivers direction in how to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. The following are examples of those strategies:

1. Be Aware of Precursors – Be aware of the behavioral precursors that the individual expresses so caregivers can provide support before the situation escalates. Also, identify precursors to *positive* behaviors and apply these to increase the likelihood for positive behavior to occur.
2. Reduce Demanding Interactions – Being told to "stop" or "calm down" can be perceived by the individual as demanding. Additionally, common forms of redirection can also be demanding depending upon the individuals. The functional assessment should be helpful in determining what is demanding to that individual.
3. Increase Valuing/Supportive/Warm Interactions – At all times, and particularly when an individual is having a difficult time, it is important that the people around him/her create a warm and supported atmosphere where he/she feels valued. This could include validating the individual's feelings.
4. Redirect – Redirect to an alternative activity if it is determined that it is not too demanding. The undesirable behavior will not be reinforced if that is the only time the individual is able to engage in it.

5. Modeling the Activity – Model or show the individual how to do the activity, then assist with the activity, providing active support as needed, encouraging but not demanding the individual complete it. Then, eventually reduce support.
6. Give Space – Be ready to help the individual as described above, or at times, give him/her some space (both in time and/or physical distance). However, be cautious that the individual is not left alone for extended periods of time.
7. Focus on the Relationship – Continue to focus on the power of the relationship between the caregiver and the individual. The task or activity is not important at this point.
8. Maintain a Calm, Relaxed Manner – It is important for the caregiver to remain calm and relaxed.
9. Use Blocking techniques –Use arms, hands, pillows, etc. to block an individual from exhibited a behavior, such as hitting himself/herself or others. For example, if someone is hitting himself/herself in the face, with an open palm, the caregiver should place his/her hand or arm over the person's arm to block attempts to get to his/her face. If someone is attempting to hit another person, the caregiver should hold hands with the person and attempt to keep his/her hands away from the caregiver.
10. Environmental Manipulations – Use environmental manipulations to keep individuals safe – e.g., keeping furniture between the individual and others; move others out of the area.
11. Focus on Safety – The focus and priority should be on safety, not teaching a lesson. Not only should the person be in a safe environment, they must also *feel* safe and valued.

V. References

General Introduction to Positive Behavior Support. *Association for Positive Behavior Support*. (2007). Retrieved July 2010, from http://www.apbs.org/new_apbs/genIntro.aspx

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Appendix 2-9-1D

EMERGENCY INTERVENTIONS TRAINING SURVEY
SUMMARY OF RESULTS
November 2011

In July 2011 the Michigan Department of Community Health (MDCH), Behavioral Health and Developmental Disabilities Administration made a request to Community Mental Health Services Program (CMHSPs) directors for information regarding their use of emergency interventions training curricula, including physical management techniques. CMHSPs were asked to forward descriptions of the training programs used, including pictures, demonstrations or step-by-step descriptions of physical techniques taught. The results of the survey are below.

A total of 41 agencies (29 CMHSPs and 12 provider organizations) submitted information. The following programs are reported as being used for training staff among the agencies:

CPI – Crisis Prevention Institute
DMH – Original Michigan Department of Mental Health Physical Intervention Training (Some with modifications)
MANDT
NAPPI –Non-Abusive Psychological and Physical Intervention
PCM –Professional Crisis Management
Locally-developed program (one)

Six entities reported using no emergency physical intervention training for staff. MDCH was given access to review the CPI, DMH, NAPPI and the locally-developed program in order to determine consistency with the Technical Requirement for Behavior Treatment Plan Review Committees (MDCH/PIHP contract Attachment 1.4.1, revised for FY'12) and the Prevention Guide that articulates MDCH's expectations for culture of gentleness. It should be noted that the MDCH will not endorse any emergency physical intervention training programs.

Below is a summary of MDCH's review of the four programs:

- Most of the staff training programs, including commercial programs, have eliminated "takedowns" from their programs. All 41 agencies reported eliminating prone restraints from their training in Michigan.
- The best staff training teaches prevention:
    - Relationship development and respect
    - Emphases lowering demands of the consumer when stress occurs
    - Emphases patience, waiting
    - Teaches those circumstances or behaviors in which to get involved
    - Teaches staff to practice preparing individuals to deal with unexpected changes in schedule or structure (a common precursor to challenging behavior for many people)
    - Provides ongoing training and modeling for staff on the job with feedback from supervisors or trainers
    - Debriefs each episode to see what went well and what solutions could be employed in the future
    - Has enough staff appropriate to individuals' needs, and available to help out. Staff assignments were made based on relationships with the person and this was pivotal in a potential crisis. Additional staff were utilized to help, calm others and move to safer location.
    - All training materials depict and model caring and respect through examples of words to be used, posture, and tone of voice

- Non-defensiveness were obvious in all aspects of training materials, process and media
- Prevention, de-escalation and safety were taught as emergency techniques to all staff.
- Individual physical intervention techniques were taught based on needs of individual served and were a minimal part of an overall proactive approach.

- Some concerning techniques that do not appear to be consistent with the Technical Requirement or the Prevention Guide's intent were found:
  - Bite releases that use pressure, cause pain or snap the jaw open and that can cause injury
  - Hair pull releases that utilize pressure or pain
  - Floor restraints including seated floor restraints that bend the person over or require staff to hold the person down (the floor always presents more risk of injury)
  - Standing restraints or transports that bend person forward put undue pressure on shoulder joints or risk falls to the floor where the face or head can be injured
  - Calls for law enforcement intervention as routine practice

Following consultation with the Center for Positive Living Supports, MDCH recommends the alternatives below to the concerning practices above. These techniques must be carried out by a lead staff using a calm voice while eliminating demands, and while other staff are removing themselves or other people from harm's way.

- Bite release and hair pulling release: move <u>into</u> the bite, or <u>into</u> the hair pulling
- Avoid the floor by redirecting the individual to a chair earlier in the process and ask the person to sit down with staff
- If the individual drops to the floor, release grip and provide a cushion for the person's head (pillow, rolled up blanket or jacket)
- Use pillows for blocking instead of arms
- Staff must be trained in how to prevent behaviors, redirect and divert from behaviors, and when that fails, respond appropriately to behaviors. Law enforcement intervention is a last resort and a result of management and staff failure.