

**WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM
ADMINISTRATIVE MANUAL**

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- 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:**

Anatomical Support: Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving an individual's physical functioning.

Aversive Techniques: 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 electric shock, foul odors, loud noises use of mouthwash, water mist or other noxious substance to cons equate behavior or to accomplish a negative association with 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, taking a prescription medication to help quit smoking) are not considered aversive for purposes of this technical requirement.

Bodily Function: The usual action of any region or organ of the body.

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.

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Emotional Harm: Impaired psychological function, growth or development of a significant nature as evidence by observable physical symptomatology or as determined by a mental health professional.

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 developed 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 or control 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.

Medical and Dental Procedures and Restraints: 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.

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Person Centered Planning: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact to prevent the individual from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each individual and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations.

Positive Behavior Support: A set of research-based strategies used to increase opportunities for an enhanced *quality of life* and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in a person's environment. Positive behavior 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, and property destruction. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

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

Prone Immobilization: extended physical restraint of an individual in a face down (prone) 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 for the purpose of control. Note: **PRONE MOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

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:

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unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings. See the prevention guide for a full list of proactive strategies and definitions.

Protective Device: A device or physical barrier to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined and incorporated in a written individual plan of service shall not be considered a restraint as defined below.

Provider: The department, each community mental health service program, each licensed hospital, each psychiatric unit and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers and contractual agents.

Psychotropic Drug: A medication administered for the treatment or amelioration of disorders of thought, mood or behavior.

Proactive 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 device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

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 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

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individual. Use of restrictive techniques requires the review and approval of the Committee.

Seclusion: The temporary 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.

Serious Physical Harm: Physical damage suffered by an individual that a physician or registered nurse determines caused or could have caused the death of an individual, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of the individual.

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.

Support Plan: A written plan that specifies the personal support services or any other supports that are developed with and provided for an individual at the time of a crisis.

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.

Treatment Plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for an individual

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Unreasonable Force: Physical management or force that is applied by an employee, volunteer, or agent of a provider to an individual in one or more of the following circumstances:

- There is no imminent risk of serious or non-serious physical harm to the individual, staff or others.
- The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
- The physical management used is not in compliance with emergency interventions authorized in the individual's plan of service.
- The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

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. **COMMITTEE 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.

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- 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 and clearly delineates the action of the committee
- ii. The Committee will be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, or licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Behavioral Health and Intellectual and Developmental Disability Supports and Services of the Medicaid Provider Manual, 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 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.
- iv. The Committee shall meet as often as needed.
- v. Expedited Review of Proposed Behavior Treatment Plans: Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergency situations. 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. If the individual requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the

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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.

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 keep all its meeting minutes and clearly delineate the actions of the Committee.
4. The Committee shall ask that a Committee member who has prepared a behavior treatment plan to be reviewed by the Committee to recuse themselves from the final decision-making.
5. 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 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

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implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

- e. 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.
- 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 Individual Plan of Service (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])
- h. On a quarterly basis, track and analyze the use of physical management and, the 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., 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

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must be available for MDHHS 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.

6. In addition, the Committee may:
 - 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.
 - c. 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.
 - d. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices
 - e. Provide specific case consultation as requested by professional staff of the agency.
 - f. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
 - g. 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.

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- 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 working with the family, guardian or caregiver will assure that all medical issues have been ruled out prior to requesting a functional behavior assessment. The referral is made by the care manager to the behavior specialist. An authorization will be obtained for behavior treatment committee and for the assessment.
 4. The Behavioral Specialist will complete a functional behavioral assessment/analysis of the individual's challenging behavior and review supporting data and literature.

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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 appropriate.

7. The Care Manager and behavior specialist 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, and emergency procedures. The Recipient Rights Officer provides consultation regarding plans rather than approve or not approve them so as to avoid potential conflict of interest. The behavior specialist is responsible for writing

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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 IPOS. 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 at least monthly or more often as specified by the BTRC and document his/her review in the clinical case record.

VII. SUPPORTING DOCUMENTS:

MDHHS Technical requirement for Behavior Treatment Plan Review Committees Final: Revisions FY '17.
Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness, June 27, 2011
MDHHS Person Centered Planning Policy June 5, 2017

Refer to:
Formal Behavior Program Plan – WMCMH Form CD007