LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 08/02/2010
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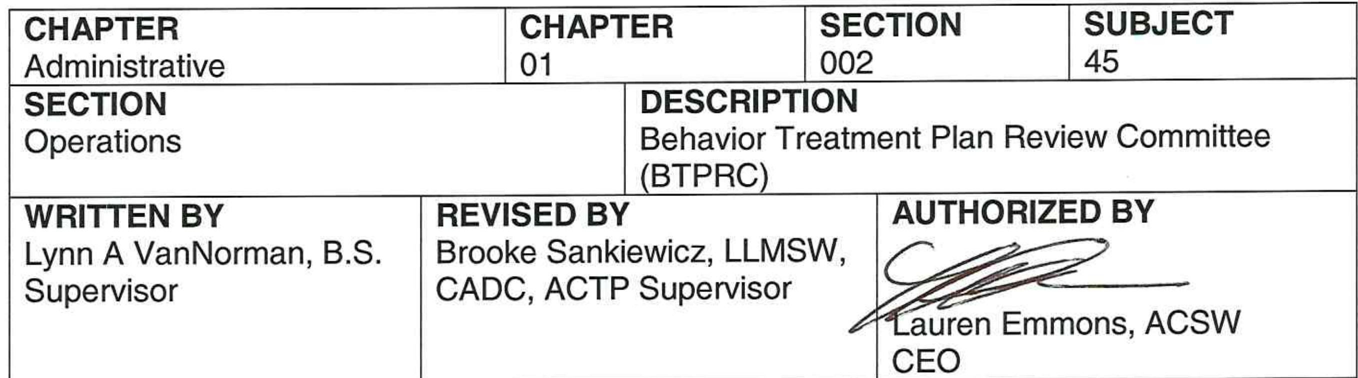

CHAPTER Administrative	**CHAPTER** 01	**SECTION** 002	**SUBJECT** 45
SECTION Operations	**DESCRIPTION** Behavior Treatment Plan Review Committee (BTPRC)		
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APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☐Independent Contractors	☐Students	☒Interns
☒Volunteers	☒Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) has a Behavior Treatment Plan Review Committee (BTPRC) to review, approve, or disapprove any Individual Plan of Service proposing to use any restrictive or intrusive techniques.

STANDARDS:

A. The Behavior Treatment Plan Review Committee, (BTPRC), is comprised of at least three individuals. At least one of these individuals must be a fully or limited licensed psychologist as defined in Section 2.4 of the Medicaid Provider Manual with specified training and experience in applied behavior analysis, and at least one member must be a licensed physician / psychiatrist as defined in the Mental Health Code at MCL 330.11 00c (10) who is not specifically required to have a behavior management background. A representative of the Office of Recipient Rights will participate on the committee as an ex officio, non-voting member, in order to provide technical assistance to the committee. The administrative support is a non-voting member of the committee. The CEO may serve as a non-voting member of the BTPRC.

B. The committee may have non-voting participants or attendees at the discretion of the committee and with consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.
C. All voting members must attend professional development (continuing education) programs in behavior management.
D. The committee will meet as often as needed, and operate under a chairperson appointed by the Chief Executive Officer (CEO).
E. The committee members including the committee chair will be appointed by the CEO for a term of not more than two years. Members may be re-appointed to consecutive terms.
F. The BTPRC will review, approve, or disapprove any Individual Plan of Service proposing to use any restrictive or intrusive techniques.
G. In emergent situations, the committee will have an expedited review of a proposed behavior treatment plan within one – two business days.
H. All decisions by the committee require a majority of members approved to vote. Approvals, modifications and denials of any behavioral treatment plan must be documented in the official BTPRC minutes.
I. If a treatment plan author is a member of the BTPRC, another professional from the author's particular discipline (e.g., psychology, social work) must be a part of the BTPRC review, and the author will abstain from voting on that treatment plan. If the committee structure does not inherently include another member from the particular author's discipline, a member may be temporarily added for individual reviews, per the committee chairperson
J. The committee will keep minutes of all BTPRC meetings delineating the actions of the committee and forwarding the minutes to the CEO and the Quality Improvement Coordinator for Quality Council and Prepaid Inpatient Health Plan reports.
K. The committee will assess the need for staff training in behavior management. The BTPRC chairperson will make the CEO aware of the need for training and will work in conjunction with supervisory and/or management staff to arrange for the training.
L. The committee will advise the CEO regarding administrative and other policies affecting behavior modification practices.

PROCEDURES:

A. The administrative assistant will add cases to the BTPRC agenda once notified by the program supervisor the Functional Behavioral Assessment has been completed in the electronic health record.

B. BTPRC will:

1. Conduct an expeditious case review, in light of current peer reviewed literature or practice guidelines, of all Individual behavior treatment plans proposing to utilize intrusive or restrictive techniques (see definitions).

2. Determine whether causal analysis of the behavior has been performed: whether positive behavioral supports have been identified and adequately pursued. When positive behavioral supports have not been identified and pursued, any proposed plan utilizing intrusive or restrictive techniques will not be approved.

3. Assure inquiry has been made about any medical, psychological or other factors the individual has which may put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

4. Not approve any behavior treatment plans proposing to use aversive techniques, physical management, seclusion or restraint in a setting where it is prohibited by law or regulations.

5. Review and determine the appropriateness of all behavior treatment plans involving the use of psychotropic medications when prescribed for behavior control purposes and when the target behavior is not due to an active psychotic process.

   a. When a person with a developmental disability is placed on psychotropic medication the proposed treatment regimen must be reviewed by the BTPRC.

   b. Persons with developmental disabilities who are already on psychotropic medication at time of case intake, must be reviewed by BTPRC within thirty days of the intake.

C. The committee will provide decisions, in writing, to the responsible staff person with an indication of the appropriate appeal process. If there is a continuing dispute, the case appeal will be referred to the Management Team and / or the CEO.

D. For each approved plan, the committee will set and document a date to re-examine the continuing need for the approved procedures. This review will occur at a frequency 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 more intrusive or restrictive the intervention or the more frequently the interventions are applied, the more often the entire behavior treatment plan should be reviewed by the committee.

E. On a quarterly basis, BTPRC will track and analyze the use of all physical management for emergency purposes, intrusive, and restrictive techniques by each individual receiving the intervention, as well as:

   a. Dates and numbers of interventions used;

   b. Setting where the behavior and interventions occurred;

   c. Observations about any events, settings or factors that may have triggered the behavior;

   d. Behaviors initiating the techniques;

   e. Documentation of the analysis performed to determine the cause of the behaviors precipitating the intervention;

   f. Description of positive behavioral supports used;

   g. Behaviors which resulted in termination of the interventions;

   h. Length of time of each intervention;

   i. Staff development and training, and supervisor's guidance to reduce use of these interventions;

j. Review and modification of development, if needed, of the individual's behavior plan.

F. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), and be available for MDHHS review. Physical management (and/or involvement with law enforcement), permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported by the committee to the QAPIP. Any injury or death occurring from the use of any behavior intervention is also considered a sentinel event and must be reported to the PIHP.

G. BTPRC will review and forward written recommendations on research projects involving risk or inconvenience to persons served to the Quality Council. All research projects which involve more than the collection of non-identifying data from records must be reviewed and approved by the BTPRC before they are initiated.

H. BTPRC may provide training to professional and support staff in areas involving behavior management and/or risk to persons served.

I. The BTPRC Chairperson will prepare and submit an annual report to the Quality Council detailing: (a) yearly functions, (b) cases reviewed and actions taken, (c) unresolved problems, and (d) recommendations for the next year. The report is to be submitted no later than October 31 of each year for incorporation in the agency's annual Quality Council Report.

J. BTPRC 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. 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 CEO.

c. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.

d. Provide specific case consultation as requested by clinical staff of the agency.

e. Assist in assuring other related standards are met, e.g., positive behavioral supports.

f. Serve another service entity (e.g., affiliate or subcontractor) if agreeable between the involved parties.

g. 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 placing the individual or others at risk or harm. The committee might recommend a limit for the number of emergency interventions used with an individual in a defined period before the mandatory initiation of a process including assessments and evaluations and possible development of a behavior treatment plan, as described in this requirement.

DEFINITIONS:

Aversive Techniques: Techniques requiring the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person) by staff to a recipient to achieve the management or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administrated (e.g. exposure therapy for anxiety, taking prescription medication to help quit smoking) are not considered aversive techniques. 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, witnessed and documented by someone other than the service provider.

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.

Functional Behavioral Assessment: An approach incorporating 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 a Functional Behavioral Assessment 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 assessment 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 a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations or events preceding positive behavior to provide more information for a positive behavior support plan. Functional Behavioral Assessment requests are made using LCCMH Form #25A Request for Psychological/ Behavioral Services.

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

Intrusive techniques: Those techniques encroaching upon the bodily integrity or the personal space of the person served for the purpose of achieving management, control, or extinction of a seriously aggressive, self-injurious or other behavior placing the individual or others at risk of physical harm. Examples of such techniques include forcing an individual to ingest a medication, receive an injection of a drug used to control or extinguish the behavior, and are not otherwise used as standard medication treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires review and approval by BTPRC

Peer-Reviewed Literature: Scholarly works typically presenting the latest original research in the field, research generally accepted by academic and professional peers for

dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are *true*, but the findings are considered authoritative *evidence* for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management will 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 person served and staff, each agency will 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 example to further clarify the definition of physical Management: Manually guiding down the hand/ fist of an individual who is striking his or her own face repeatedly causing harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. 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 restricting 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 preventing 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 problem behavior by conducting a functional assessment and by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and system change to enhance quality of life and reduce problem behaviors

such as self-injury, aggression, property destruction, pica, defiance, and disruption. Positive Behavioral 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.

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 placing 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 he 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 licensed hospital. This definition excludes:

a. Anatomical or Physical support ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving and individual's physical functioning.

b. 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.

c. 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 will only be used as specified in the individual written plan of service for medical or dental procedures.

d. 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 include the systematic use of mechanical restraint, physical management, or seclusion (all of which restrict freedom of movement, prohibiting communication with others to achieve therapeutic objectives, prohibiting ordinary access to meals, use of the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual and any technique which can be described as an affront to the dignity of the person served. Restrictive techniques include the use of a drug or medication when it is used as a restriction to manage an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of restrictive techniques requires the review and approval of the committee.

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 person served, the legal guardian, and the parent with legal custody of a minor child or a designated patient advocate prior to the implementation of any behavior treatment intervention including 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 person served, guardian or parent of a minor person served may only occur when the person served has been adjudicated pursuant to the provisions of Section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

REFERENCES:

LCCMH Form #25A Request for Psychological/Behavioral Services
MCL 330.1712 Michigan Mental Health Code
MCL 330.1740 Michigan Mental Health Code
MCL 330.1742 Michigan Mental Health Code

MDHHS Master Contract requirements – Technical Requirement for Behavior Treatment Plan Review Committees
Michigan Department of Health and Human Services Administrative Rule 330.7199(2)(g)
Region 10 PIHP Behavior Management Review Policy 01.04.04

BS:mgr

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This policy supersedes #08/10015 dated 08/02/2010.

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