LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 08/02/2010
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CHAPTER Service Delivery	**CHAPTER** 02	**SECTION** 004	**SUBJECT** 35
SECTION Clinical and Support Services	**DESCRIPTION** Behavior Assessment, Management and Behavior Treatment Plans		
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APPLICATION:

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

POLICY:

Lapeer County Community Mental Health (LCCMH) utilizes a culture of gentleness and has established procedures for assessments with proactive behavior management strategies to assist persons served who exhibit challenging behaviors.

STANDARDS:

A. Positive behavioral approaches are used to reduce or eliminate negative or aggressive actions exhibited by the persons served.

B. Physical management is never a component of an approved behavior treatment plan.

C. LCCMH Staff are be trained at orientation in positive behavioral supports and de-escalation techniques.

D. The Individual Plan of Service (IPOS) focuses on ongoing positive interactions, with clearly defined emergency interventions used only to prevent harm to the person served or others. Proactive strategies for assisting the individual exhibiting

aggression toward themselves or others becomes part of the Individual Plan of Service (IPOS).

E. Restrictive behavior management techniques are used only after any medical reason for the disruptive behavior has been ruled out, and all other positive approaches and methods have been documented to have failed and the person's behaviors put them or others at serious risk of harm.

F. All Behavior Plans with restrictive techniques must be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC) prior to implementation.

G. The Primary Case holder is responsible for ensuring a Functional Behavioral Assessment is completed in the electronic health record prior to the implementation of a Behavior Treatment Plan.

H. Functional Behavioral Assessments are used for treatment planning for persons served with challenging behaviors. LCCMH staff request a Functional Behavioral Assessment and evaluation to rule out any physical, medical, trauma, interpersonal relationships, and environmental conditions which might be the cause of the behaviors.

   1. Functional Behavioral Assessments are conducted by a clinician with at least a master's degree in psychology or social work licensed by the State of Michigan, who has training in supporting individuals with challenging behaviors.

   2. The clinician consults with the treatment team.

   3. The clinician assists with the development of a behavior treatment plan incorporated into the IPOS with use of positive strategies for assisting the person served with reducing or eliminating the challenging behavior.

I. LCCMH staff are prohibited from developing treatment plans for the persons served which include:

   1. Seclusion

   2. Use of restraint

   3. Electro-convulsive therapy

4. Psychosurgery
5. Experimental drugs / medications
6. Physical punishment
7. Aversive techniques
8. Denials of nutritionally adequate diet via loss of meals.
9. Physical Management

J. When interventions in the IPOS or behavioral treatment plan are not successful and there is imminent danger of serious harm to the person served or others, emergency physical interventions may be used to ensure safety.

PROCEDURES:

A. Staff listens, observes, and interprets the behavioral communications being presented, and respond in a proactive manner to help reduce or eliminate negative or aggressive actions by the person being served.

B. The person-centered planning process used in the development of a written Individual Plan of Service (IPOS) identifies when a Behavior Treatment Plan needs to be developed. There must be documentation a Functional Behavioral Assessment has been conducted to rule out physical, medical or environmental causes of the behavior; and there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the behavior.

C. Access to Functional Behavioral Assessments

1. The person served referred for assistance with challenging behavior must be an open case to LCCMH.
2. At the time of the Biopsychosocial Assessment (BPS) or Periodic Review (PR), the treatment team believes the behavior of the person served places them at risk to themselves or others. This is clearly documented at the time of the BPS Assessment.

3. To determine eligibility for a Functional Behavioral Assessment, the case holder fills out the "Request for Psychological/Behavioral Services" Form #25A and submit the form and a copy of the BPS or PR to their supervisor for approval.

4. If the assessment is denied the supervisor provides, in writing, rational for denial.

5. Denial of services may be based on (but not limited to):

    a. Lack of information to make a determination.

    b. Previous interventions have not been tried.

    c. Behavior does not pose a risk to the person or others.

6. Upon approval, the supervisor forwards the referral to the designated clinical supervisor.

7. The designated clinical supervisor forwards the referral to the appropriate clinician.

8. The clinician follows up with primary case holder upon completion of the Functional Behavioral Assessment.

D. Behavior Treatment Plans must be developed through the person-centered planning processes. All Individual Plans of Service proposing the use of restrictive / intrusive interventions must be reviewed by the BTPRC on a quarterly basis with the intention of reducing or eliminating the need for the restrictive technique (See BTPRC Policy 01.002.45). The IPOS also requires special consent of the individual, parent and/or guardian.

E. Written special consent on LCCMH Form #378 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 including intrusive or restrictive procedures or interventions.

F. Behavior management procedures can become restrictive by virtue of:

1. An individual's resistance to the procedures, thus necessitating the use of physical prompting / guidance by staff.

2. The procedure itself, while seemingly mild, may take on a feature of risk due to the individual's emotional reaction (e.g. self-abuse or physical aggression) to that particular procedure.

G. Behavior Treatment Plans proposing the use of physical management and/or the involvement of law enforcement in a non-emergent situation, aversive techniques, or seclusion or restraint in a setting where it is prohibited by law is not approved by the BTPRC.

Use of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than three (3) times within a 30-day period, the individual's written IPOS must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS and MDHHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, 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.

H. If a primary case holder is requesting a case to be presented to the committee, as a risk, they should first get approval from their supervisor. For any IPOS proposing the use of restrictive or intrusive techniques as defined by this policy, the primary case holder completes the referral form for the Functional Behavioral Assessment and the Behavioral Review Form in OASIS. The primary case holder then notifies their supervisor to be added to the BTPRC agenda.

I. The administrative assistant assigned to the committee notifies the primary case holder when they have a case to present to the committee.

J. Behavior Treatment Plans containing any restrictive components are forwarded to the committee for review and are accompanied by:

1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior

2. The 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, which have been attempted 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 supporting the proposed restrictive or intrusive techniques

7. References to the literature should be included, and where the intervention had limited or no support in the literature, why the plan is the best option available

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s) using the In-Service / Training Record Form #33.

9. Documentation of when and under what circumstances the restriction is no longer be necessary

K. The BTPRC determines whether analysis of the causes of the behavior has been performed; whether behavioral proactive supports and interventions have been adequately pursued; and, where neither has occurred, will not approve any proposed plan for utilizing intrusive or restrictive techniques.

L. Once a decision to approve a behavior treatment plan has been made by the committee, consent must be obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate. Once these are obtained the treatment plan becomes part of the record of the person served. The individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate has the right to request a review of the written IPOS, including the right to request the person-centered planning be re-convened, in order to revisit the behavior treatment plan (MCL 330.1712 [2])

M. When the treatment plan includes restrictive/intrusive components it details any anticipated risks and be reviewed by the BTPRC for approval prior to implementation. If such risks arise during the course of treatment, and were not previously reviewed by the BTPRC, the program should be brought to the BTPRC at the earliest possible time.

N. Medications requiring review by the BTPRC:

1. When a person served is placed on psychotropic medication, they and their guardian are informed regarding the effects and aversive effects of the medication, both short term and long range, with special emphasis on Tardive Dyskinesia (include handout).

2. When a person is receiving services from LCCMH, the primary case holder seeks a release of information if the person served is receiving psychotropic medication outside the agency for purposes of controlling behavior aside from the aforementioned psychotic process. The primary case holder also requests of the prescribing physician, a written rational for prescribing the medication.

3. When a person with a developmental disability is placed on psychotropic medication not approved for the assigned or designated diagnosis, the proposed treatment regimen must be reviewed by the BTPRC. The primary case holder ensures a Functional Behavioral Assessment has been completed or referral made prior to the initial review, complete the Behavioral Review in OASIS, then let their supervisor know the case is ready to be placed on the BTPRC agenda.

4. For those persons with developmental disabilities who are already on psychotropic medication at time of case intake, the case must be submitted for BTPRC review within thirty days of the intake. The assigned case holder should proceed as described in number 3 above.

O. Monitoring and Discontinuation of a Behavior Treatment Plan

1. If a behavior treatment plan has been developed and monitored by the case holder, BTPRC assesses the continued need for behavioral interventions during quarterly reviews.

2. BTPRC requests data from the Behavior Tracking Form #386, to support the current plan or to reduce restrictive/intrusive interventions in the behavior treatment plan.

P. 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 and 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.

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 is 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.

Imminent Risk: An event/action about to occur likely to 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 themselves 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 them 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 themselves. 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 them 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 them from moving out of the prone position.

Physical Punishment: Involves the use of physical force with the intention of causing a person served bodily pain or discomfort. For example: spanking, hitting, slapping, or pinching.

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 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 placing 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 requiring 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.

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:

Behavior Treatment Plan Review Committee Policy # 01.002.45

LCCMH Form #337 In-Service/Training Record

Michigan Mental Health Code

BS:lr

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This policy supersedes
#08/10014 dated 08/02/2010.
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