COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY & PROCEDURE

DATE: September 25, 2024

RESCINDS: June 26, 2024

CATEGORY: Client Services

SUBJECT: Behavior Treatment Committee

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that any restrictive or intrusive program elements of any Individual Plan of Service (IPOS) be used only as a last resort and when absolutely necessary to protect the health and safety of the person and others when people exhibit seriously aggressive, self-injurious or other challenging behaviors that place the person or others at imminent risk of physical harm. Any plan that proposes restrictive or intrusive treatment techniques, including psychoactive medication for the purposes of behavior control, and the use of protective devices, must be reviewed and approved by the Agency's Behavior Treatment Committee (BTC). Aversive techniques and seclusion, as defined below, are prohibited.

PURPOSE: To establish standards and guidelines for the professional review, approval or disapproval and monitoring of plans that proposes the use of intrusive or restrictive program elements or the use of psychoactive medication for behavior control.

DEFINITIONS:

Aversive Techniques: Techniques that are punishing, physically painful, emotionally frightening, deprivational, or put a person at medical risk when they are used; or any technique that requires the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or that would have a specific unpleasant effect on a particular person) to achieve management, control or extinction of seriously aggressive, self-injurious or other behavior that places the person 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 a target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating a target behavior. The *voluntary* use by the person of an intervention such as antabuse for alcoholism, for example, is not considered an aversive technique for purposes of this policy. 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 (such as exposure therapy for anxiety) are not considered aversive for purposes of this policy. **USE OF AVERSIVE TECHNIQUES IS PROHIBITED**.

Consent: A written agreement signed by the person, the parent of a minor, or a person's legal representative with authority to execute consent, or a verbal agreement of a person 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 Michigan Department of Health and Human Services(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: Techniques that encroach upon the bodily integrity or the personal space of the person to achieve treatment, management, control or extinction of a seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. An example is the use of direct observation procedures during times that would otherwise be considered private by an average person; or use of a medication or drug that is not a standard treatment or dosage for the person's condition. Use of intrusive techniques as defined here requires **REVIEW AND APPROVAL** by the Behavior Treatment Committee.

Physical Management: An agency-approved technique used by trained employees as an emergency intervention to restrict the movement of a person by continued direct physical contact in spite of the person's resistance in order to prevent the person from physically harming himself, herself, or others.

Physical management shall only be used on an emergency basis when the person or the situation is presenting an imminent risk of serious physical harm to himself/herself or others. 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. Physical management shall not be included as a component in a behavior treatment plan.

Prone Immobilization: Extended physical management of a person in a prone (face down) position, usually on the floor, where force is applied to his or body in a manner that prevents him or her from moving out of the prone position. **PRONE IMMOBILIZATION OF A PERSON OR ANY PHYSICAL MANAGEMENT THAT RESTRICTS A PERSON'S RESPIRATORY PROCESS, FOR THE PURPOSE OF BEHAVIOR CONTROL, IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

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 person 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 qualify 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.

Request For Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of a person exhibiting seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. Law enforcement should be called for assistance **ONLY WHEN: CAREGIVERS ARE UNABLE TO REMOVE OTHER PEOPLE 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 PERSON OR OTHERS.**

Restraint: The use of a physical or mechanical device to restrict a person's movement; specifically, anything that immobilizes or reduces the ability of the person to move his/her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restraint does not include the use of a device primarily intended to provide anatomical or physical support that is ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving a person's physical functioning; or safety devices required by law, such as car seat belts or child car seats used in vehicles. **THE USE OF PHYSICAL OR MECHANICAL DEVICES USED AS RESTRAINT IS PROHIBITED IN ALL AGENCY PROGRAMS UNDER ANY CIRCUMSTANCES.**

This definition excludes the following:

Anatomical Or Physical Support: Body positioning or a physical support ordered by a physician, physical or occupational therapist for the purpose of maintaining or improving a person's physical functioning.

Protective Device: A device or physical barrier to prevent the person from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined here shall not be considered a "restraint" as defined above. However, it must be incorporated in the IPOS through a behavior treatment plan which has been reviewed and approved by the BTC and received special consent from the person or his/her legal representative.

Medical Restraint: The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the person quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the IPOS 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 person's rights as specified in the Mental Health Code and the federal Balanced Budget Act. These techniques are used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restrictive techniques include the use of a psycho-active medication for the purpose of behavior control. Any use of psycho-active medication prescribed for persons with a primary diagnosis of an intellectual/developmental disability and an existing secondary mental illness diagnosis must conform to accepted standards of practice for that specific diagnosis. Use of restrictive techniques as defined here requires **REVIEW AND APPROVAL** by the Behavior Treatment Committee.

Seclusion: The placement of a person in a room, alone, when freedom to leave the segregated room or area is prevented by any means. **SECLUSION IS PROHIBITED IN ANY AGENCY PROGRAM UNDER ANY CIRCUMSTANCES.**

Special Consent: The written consent of the person, 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 violate the person's rights. The general consent to the Individual Plan of Service is not sufficient to authorize implementation of a behavior treatment plan that includes intrusive and/or restrictive techniques. Implementation of a behavior treatment plan without the special consent of the person, guardian or parent of a minor may ONLY occur when the person has been adjudicated pursuant to the provision of one or more of the following sections of the Mental Health Code:

-469a Treatment program as alternative to hospitalization, court order;

-472a Initial, second or continuing order for involuntary mental health treatment, duration of order hearing;

-473 Petition for second or continuing order of involuntary mental health treatment, contents, clinical certificate;

-515 Criteria for judicial admission;

-518 Findings, disposition of the court regarding judicial admission;

-519 Alternative care and treatment.

PROCEDURE:

I. CCMHS shall have an established Behavior Treatment Committee (BTC) that is responsible for the review and approval or disapproval of all behavior treatment plans that propose the use of restrictive or intrusive interventions. If CCMHS delegates the functions of the Committee to a contracted mental health service provider, CCMHS will monitor that Committee to assure compliance with this policy.

II. Behavior Treatment Committee Membership:

   A. This specially constituted body shall be comprised of at least three people, two of whom meet the following criteria:

      - a board-certified behavior analyst (BCBA) or licensed behavior analyst, or a full limited licensed, or temporary limited licensed psychologist with formal training and experience in applied behavior analysis.
      - a licensed physician or psychiatrist.

   B. A representative of the Office of Recipient Rights shall participate on the BTC as an ex-officio, non-voting member in order to provide consultation and technical assistance to the BTC.

   C. At least one of the BTC members shall not be the developer or implementer of the behavior treatment plan.

   D. Other non-voting members may be added at the Committee's discretion and with the consent of the person whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

   E. The chairperson and members of the BTC are appointed by the Executive Director for a term of not more than two years. Members may be re-appointed to consecutive terms.

   F. The psychologist/BCBA or physician must be present during the review and approval process.

III. Behavior Treatment Committee Functions:

   A. Review and Approval or Disapproval of Proposed Plans:

      1. The BTC shall expeditiously review all program plans that involve the use of restrictive or intrusive program elements as defined above. Approval (or disapproval) of proposed program plans shall be done in light of current peer-reviewed psychological/psychiatric literature or practice guidelines and according to the "Behavioral Treatment Plan Standards" listed in Paragraph IV.

      2. Any behavior treatment plan that proposes to use seclusion, restraint, physical management in a non-emergent situation or aversive techniques as defined above shall not be approved by the BTC.

3. Expedited reviews of proposed behavior treatment plans will be completed in emergent situations, according to the Agency's "Emergency BTC Approval" Procedure. Expedited plan reviews may be requested when the plan requires immediate implementation. Every attempt will be made to review and approve the plan within 48 hours of the request.

B. Each plan shall be reviewed and approved or disapproved as expeditiously as possible.

C. Any Behavior Treatment Committee member who has prepared a behavior treatment plan to be reviewed must excuse him/herself from the final decision-making.

D. When plans are approved, the BTC shall establish the frequency at which it will review the plan's implementation. Plan reviews shall indicate the specific restrictive plan elements being utilized and note any progress or problems associated with the implementation of the approved plan. Any medication changes since the time of plan approval or last review shall be duly noted. Progress will be noted with the intent of replacing restrictive program procedures with more positive treatment strategies as progress is realized. The BTC shall also offer consultation to providers and plan authors when there is a lack of progress or problems associated with the implementation of the plan. Ongoing approval of the plan must be based on a continued risk/benefit analysis of the behaviors present and consider the health and safety needs of the person that either support or contraindicate continued implementation. Plan approvals and reviews must be signed by the BTC members present, including at least the required members as noted under Paragraph II.

1. A review of each plan with intrusive or restrictive techniques shall occur no less than quarterly; or more frequently if clinically indicated. In addition, the person, 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 (MCL330.1712[2].

2. The entire behavior treatment plan should be reviewed by the Behavior Treatment Committee based on the intensity of the intrusive or restrictive interventions and the frequency with which they are applied.

   a. The Behavior Treatment Committee's approval and review of the plan will be documented in the person's clinical record.

E. When plans are not approved, alternatives or recommendations should be offered.

F. The BTC will meet as often as necessary, but no less than quarterly, and on an emergency basis as needed to ensure that appropriate and timely approval/disapproval and reviews of all proposed plans are completed.

G. The BTC shall keep minutes of each meeting to clearly delineate its actions.

H. The BTC will track and analyze incidents of the use of emergency physical management and/or law enforcement involvement for behavior emergencies and the use of intrusive and restrictive techniques at every meeting. These reviews will include:

1. Dates and numbers of interventions used;
2. The settings (e.g., home or work) where behaviors and interventions occurred;
3. The incident report coding of the event;
4. Observations about any events, settings, or factors that may have triggered the behavior;
5. Behaviors that initiated the techniques;

6. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention;
7. Description of positive behavioral supports used;
8. Behaviors that resulted in termination of the interventions;
9. Length of time of each intervention;
10. Staff development and training and supervisory guidance to reduce the use of these interventions;
11. Review and modification or development, if needed, of the person's behavior plan.

b. If there is a continued pattern of physical management to manage challenging behaviors, the BTC is responsible to initiate quality improvement efforts. Should use occur more than three (3) times within a thirty (30) day period for a person, the IPOS must be revisited through the person-centered planning process and modified if needed.

I. The BTC Chair or designee will report required information to the Quality Improvement Committee for review and analysis quarterly. Information will include information related to the use of physical management, use of law enforcement, and any injuries or death as a result of either of those interventions. The Qualify Improvement Committee will evaluate any trends and make recommendations for further agency action.

J. CCMHS will appoint a representative to the NorthCare Network Clinical Practice Quality Improvement Committee and provide any information requested or required by NorthCare.

K. At least every other year, the BTC will evaluate the effectiveness of the behavior plans by surveying stakeholders including the guardians, family members and staff.

IV. Behavior Treatment Plan Standards:

A. Any plan that involves only positive reinforcement and/or non-coercive teaching procedures are considered non-restrictive and do not need approval through the BTC process.

B. Any behavior treatment plan with restrictive or intrusive elements shall be:

1. developed through the person-centered planning process that involves the person, their family members, and/or legal guardian or representative;
2. clearly documented in the plan of service;
3. developed with the least restrictive interventions available to ensure the health and safety of both the person and others in their environment;
4. time limited;
5. approved by the Behavior Treatment Committee prior to implementation.

C. Prior to approval, the Behavior Treatment Committee must be provided with:

1. results of assessments and evaluations to rule out physical, medical and environmental causes that might be the cause of the challenging behaviors;
2. a functional behavior assessment;
3. results of inquiries about any medical, psychological or other factors that might put the person subjected to intrusive or restrictive techniques at high risk of death, injury or trauma;

4. evidence that positive behavioral supports and interventions, including their amount, scope and duration, to change the behavior have been attempted and proved to be unsuccessful; or there is other sufficient clinical assessment and opinion to use the intervention in order to reduce risk of death, injury or trauma to the person and/or others;
5. a plan to identify continued efforts to find other options;
6. a plan for monitoring the treatment plan;
7. a plan for employee training to assure consistent implementation and documentation of the intervention(s).

D. Behavior Treatment Committee approval must occur prior to the implementation of the proposed plan.

E. Prior written special consent, as defined above, must be given by the person, or his/her guardian if one has been appointed, or the parent with legal custody of a minor before the plan can be approved by the Behavior Treatment Committee.

Consent from the person served should be attempted to be attained in all situations, but is not essential if a legal representative provides consent. If a consent from the person served is not able to be obtained, a rationale will be written on the consent to indicate the lack of signature. A written consent should be obtained as soon as possible if a verbal is obtained.

CROSS REFERENCE:

CCMHS Policy - Management of Behavioral Emergency

CCMHS Policy – PRN Medications

CCMHS Policy – Informed Consent to Psychotropic Chemotherapy

CCMHS Policy – Report, Investigation, and Review of Unusual Incidents

NorthCare Network Behavior Treatment Review Policy