COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY
POLICIES AND PROCEDURES

No. 06-001

Prepared by:

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Subject: Behavioral Support Committee

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I. POLICY:

Community Mental Health Services will provide a set of strategies used to increase the quality of life and decrease problem behavior by teaching new skills and making changes in the individualsô environment. These strategies will be the least restrictive and will provide a mechanism by which treatment for behavioral concerns are systematically and thoroughly reviewed. CMH will not employ the use of aversive techniques, seclusion or restraint as defined by the Department of Community Health.

II. PURPOSE

To review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. Ensure that all behavioral support plans are as least restrictive and intrusive as possible, and protect the rights of the individuals we serve.

III. APPLICATION

All individuals with developmental disabilities or mental illness who receive services from Muskegon County Community Mental Health.

IV. DEFINITIONS:

APPLIED BEHAVIOR ANALYSIS: means the organized field of study which has as its objective the acquisition of knowledge about behavior using accepted principles of inquiry based on operant and respondent conditioning theory. It also refers to a set of techniques for modifying behavior toward socially meaningful ends based on these conceptions of behavior. Although this field of study is a recognized sub-specialty in the psychology discipline, not all practitioners are psychologists, and such training may be acquired in a variety of disciplines.

AVERSIVE TECHNIQUES: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person **or** stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include, use of mouthwash, water mist, or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, as use of nausea-generating medication to establish a negative association with a target behavior or fro directly consequating target behavior. The voluntary use by the individual of an intervention such as antabuse for alcoholism, for example, is not considered an aversive technique for purposes of this policy. Use of aversive is prohibited without MDCH review and approval.

BEHAVIOR MODIFICATION: The systematic application of principles of general behavior theory to the development of adaptive behavior and/or elimination of behavioral excesses/deficits, consistent with therapeutic objectives.

EVIDENCE-BASED PRACTICE: The integration of the best research evidence with clinical expertise and consumer values, or clinical interventions or practices, for which there is consistent scientific evidence proving that they repeatedly produce specific, intended results.

FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA): an approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or ñfunctionò 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. 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 preceded positive behavior to provide more information for a positive behavior support plan.

EMERGENCY INTERVENTIONS: There are only two emergency interventions approved by MDCH for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention.

IMMINENT RISK: An event/action that is about to occur that will likely results 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. Example**s** of such techniques include the use

of a medication or drug when it is used to manage, control of extinguish an individualôs behavior or restrict the individuals freedom of movement and is a standard treatment or dosage for the individual condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

PHYSICAL MANAGEMENT: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individualôs resistance order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff an agency shall designate emergency physical management techniques to be utilized during emergency situations. The term ñphysical managementò 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 involving prone immobilization of an individual**,** as well as any physical management that restricts a personôs respiratory process for behavioral control purposes is prohibited under any circumstances.

POSITIVE BEHAVIOR SUPPORT: A set of researched-based strategies used to increase ***quality of life*** and decrease seriously aggressive, self ï injurious or other behaviors that place the individual or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in a personôs environment. Positive behavior support combines valued outcomes, behavioral and biomedical science, validated procedures, and systems change to enhance quality of life and reduce problem behaviors such as self- injury, aggression, property destruction, pica, defiance and disruption. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work and in the community.

PRACTICE OR TREATMENT GUIDELINES: Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

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

REACTIVE STRATEGIES IN A CULUTRE OF GENTLENESS: strategies within a Positive Behavior Support Plan used to respond when individual 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 INTERVENION: calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a serious 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: Any physical or mechanical device to restrict an individualôs movement at the order of a physician. The use of physical or mechanical devices used as restraint is prohibited except in a state-operated facility or a licensed hospital.

RESTRICTIVE TECHNIQUES: Those techniques which, when implemented, will result in the limitation of the individualôs rights as specified in the Michigan Mental Health Code and the Federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm include: limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes)**;** using the Craig (or veiled) bed or any other limitation of the freedom of movement of an individual**.** Use of restrictive techniques requires the review and approval of the Committee.

SECLUSION: The placement of an individual in a room alone where egress is prevented by any means. Seclusion is prohibited except in a hospital or center operated by the Department, a hospital licensed by the Department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

SPECIAL CONSENT: Obtaining the written consent of the individual ~~or~~ 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 individualôs 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. Special consent will be received on CMH form # 812 (Attachment A) ~~I~~mplementation of a behavior treatment intervention without consent of the individual, guardian or parent or a minor individual may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518 or 519 or the Mental Health Code.

V. PROCEDURE:

A. The organization of the committee shall include:

1. The Director or designee shall appoint an Interdisciplinary Behavioral Support Committee comprised of at least five individuals, at least three of whom have both formal training and at least one year of experience in applied behavior analysis. Such training shall have been at the graduate level at an accredited college or university. In addition, such persons shall attend professional development (continuing education) programs in behavioral intervention. At least one of the aforementioned individuals shall be a full or limited licensed Psychologist with the specified training and experience in applied behavior analysis; at least one member shall be a licensed Physician/Psychiatrist who is not specifically required to have the behavior modification background and one member shall be the Recipient Rights Officer/Advisor. Other non-voting members may be added at the Committeeôs discretion and with the consent of the individual whose behavior treatment is being reviewed, such as an advocate or Certified Peer Support Specialist.

2. Committee members shall be appointed for a term of two years. Members may be re-appointed to consecutive terms.

3. The Behavior Support Committee chairperson reports to the appropriate Quality Council Committee as designated by the Director. He/she provides, on a quarterly basis, a report which summarizes the Committee's activity relative to (at minimum) outcome indicators established by the Behavior Support Committee. Committee findings are included in the Agency's Quality Improvement Plan.

4. A time frame specific to each approved plan for re-examination of the continuing need for the approved procedures. Such a time shall be no more than 120 days.

5. Meetings scheduled semi-monthly or as needed and directed by the chairperson appointed by the appropriate Quality Council Committee as designated by the Director. Interim approval or expedited plan reviews may be requested when, based on the data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

6. The Chairperson keeps all Behavioral Support Committee meeting minutes, and clearly delineates the actions of the committee.

7. The author of a Behavioral Support Plan shall be a licensed psychologist or masters level social worker, with training in behavioral analysis. The author will abstain from decision making when presenting their own plans.

8. The author of the plan shall assure that all responsible staff is inserviced prior to implementation of the plan.

B. The functions of the Behavioral Support Committee shall be to:

1. Review and approve (or disapprove), intrusive and/or restrictive Behavioral Support Plans (see Formal Behavioral Support Plan, CMH-330, Attachment B) requiring informed consent by the recipient/guardian (see Hierarchy of Interventions, Attachment C).

2. Review and approve all Level II and III Behavioral Support Plans (see Hierarchy of Interventions, Attachment C).

3. Review and approve all Level II and III plans to assure compliance with regard to Recipient Rights policies and standards.

4. Be familiar with all litigation involving the use of behavior modification in the public mental health system.

5. Review and recommend action regarding current and draft policies on Agency behavior support and technology.

6. Review and recommend action regarding Agency research effecting (on or for) individuals we serve.

7. Design and implement Agency training in Applied Behavioral Analysis.

8. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   a) Dates and the number of interventions used.
   b) The settings (e.g., individualôs home or work) where behaviors and interventions occurred.
   c) Observations about any events, setting, or factors that may have triggered the behavior.
   d) Behaviors that initiated the techniques.
   e) Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
   f) Description of positive behavioral supports used.
   g) Behaviors that resulted in termination of the interventions.

h) Length of time of each intervention.
i) Staff development and training and supervisory guidance to reduce the use of these interventions.

B. In addition, the Committee may:

1. Advise and recommend to the agency the need for specific training in positive behavioral supports, behavior treatment for staff.

2. At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agencyôs needs and approved in advance by the agency.

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

4. Provide specific case consultations as requested by professional staff of the agency.

5. Assist in assuring that other related standards are met, e.g., aversive conditioning standards

6. Service another service entity (e.g. Affiliate or subcontractor) if agreeable between the involved parties.

7. Provide specific case consultation as requested by professional staff.

3. Assist in assuring that other related standards are met.

Professional staff will utilize the Hierarchy of Interventions (Attachment C) to develop their interventions and assess level of approval/consent necessary.

VI. REFERENCES AND LEGAL AUTHORITY:

A. The Michigan Mental Health Code. Public Act 258, of 1974.
MCL 33.1740 Michigan Mental Health Code
MCL 330.1742 Michigan Mental Health Code
MDCH Administrative Rule 7001 (l)
MDCH Administrative Rule 7001 ®

B. Standards for Intermediate Care Facilities for the Mentally Retarded.

C. Accreditation Council for Mental Retardation and Developmental Disabilities - Standards.

D. CARF Standards

E. Guidelines for the Practice of Behavior Modification in Community Settings, by the Institute for the Study of Mental Retardation and Related Disabilities.

F. Public Mental Health Manual, Volume IV-H-001-0003

G. Mental Retardation Definitions, Classifications, and Systems of Support. 10th Edition AAMR

H. 1997 Federal Balanced Budget Act at 42 CFR 438.100 MCL 330.1712, Michigan Mental Health Code

I. MDCH: Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness. (June 27, 2011).

TDW

Attachment C

COMMUNITY MENTAL HEALTH SERVICES OF MUSKEGON COUNTY

Hierarchy of Interventions

Below is a list of behavior modification procedures which may be used in Formal Behavioral Support Plans. These planned interventions are typically developed for situations and behavior which occur on a consistent basis over time (more than twice per month). The plans are then presented to the Behavioral Support Committee for review and approval. Staff is trained and the plan is implemented. There may be times/circumstances when some of these techniques may be used on an emergency basis. Please refer to Policy #4-009 for further clarification.

The interventions listed below have been divided into three different levels. The levels of interventions are presented from least restrictive to most restrictive. This list provides general guidelines for those involved with behavior modification interventions and submission of these plans to the Behavioral Support Committee.

Level I Procedures

The following is a list of positive procedures. These interventions are methods of reinforcing or teaching. Behavior modification plans involving the use of only these techniques do not have to be submitted and reviewed by the Behavioral Support Committee**.** However, if the author of the plan would like to have it reviewed; the Behavioral Support Committee will comply. This is not an exhaustive list.

1. Positive Reinforcement: Behavior that is followed by a consequence that increases the probability of the behavior occurring again under similar circumstances.

2. Differential Reinforcement of Other Behavior (DRO):
   Delivery of a reinforcer after any response except the target response.

3. Differential Reinforcement of Incompatible Responding (DRI):
   Delivery of a reinforcer after a response that is incompatible or competes with a target response that is to be suppressed.

4. Differential Reinforcement of Low-Rates of Behavior (DRL):
   Used to decelerate a high frequency behavior. Delivery of a reinforcer for reductions in the performance of a target behavior.

5. Fading: The gradual removal of discriminative stimuli including such prompts as instructions or physical guidance.

6. Shaping: Developing a new behavior by reinforcing successive approximations toward the terminal response.

7. Forward Chaining: Simple responses already in the repertoire of the individual are reinforced in sequence to form more complex behaviors. May also include graduated guidance.

8. Backward Chaining: The last step in a training sequence is taught first, the next to last next, and so on until the entire chain is emitted as a single complex behavior.

*Graduated guidance (a gentle physical prompt) is usually included as part of the fading, shaping, and chaining procedures.

9. Token Economy: A reinforcement system in which tokens are earned for a variety of behaviors and are used to purchase a variety of back-up reinforcers. Level one toke economies do not include response cost.

10. Contingency contract: A behavior modification program in which an agreement is made between a person who wishes to change behavior and the person whose behavior is to be changed. The contract specifies the relationship between behavior and its consequences.

11. Modeling: A demonstration of all or part of a target behavior for a learner.

12. Social Disapproval: Explaining in a firm, but not harsh, tone of voice that a behavior that has just been emitted is incorrect and/or inappropriate.

13. Extinction: A procedure in which the reinforcer is no longer delivered for a previously reinforced response.

Level II Procedures

Level II procedures are presented below. Any behavior modification plan which includes one or more of these procedures must be reviewed and approved by the Behavior Support Committee before being implemented. Again, this list is not comprehensive. Administration of this type of intervention should be conducted with periodic professional supervision.

1. Non-Exclusionary Time-Out: An inappropriate target behavior results in access reinforcement being removed for a specified period of time. In this instance, certain reinforcing materials or social approval is withdrawn for a specific period of time contingent upon an instance of inappropriate behavior.

2. Satiation: A reinforcer that has been maintaining an undesirable behavior is presented non-contingently in unlimited amounts. Providing an excessive amount of the reinforcer.

Level III Procedures

Contained in this category are behavior modification procedures which are considered most restrictive. Before a Behavioral Support Plan which contains one of these interventions is implemented several levels of consent must be obtained. The Behavioral Support Committee must approve the plan and the recipient or the recipient's guardian must provide written informed consent. Otherwise, a behavior modification plan of this type cannot be implemented. Consent may be withdrawn verbally (documented by staff) or in written form, at any time by the recipient or their guardian.

Implementation of a Level III plan requires staff to be trained by the author or his/her designee. This is not a definitive list and should not be considered as such.

1. Response Cost: A positive reinforcer is contingently withdrawn following an instance of a target response. With this procedure, unlike timeout, no time limit to the withdrawal of the reinforcer is specified. Fines are a common form of response cost.

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

3. Overcorrection: Two main elements are involved in overcorrection procedures: (1) Restitution-excessively restoring a disrupted environment to its original condition and (2) Positive practice-repeated trials of the correct/appropriate behavior are thoroughly rehearsed in practice. Negative practice overcorrection is not permitted.

4. Non-Abusive Restraint and Control: The use of the least restrictive amount of CMH approved and trained non-abusive restraint and control/NAPPI techniques, in order to prevent the individual from injuring self, others, or significant property destruction.

   Under certain circumstances, an approved intervention technique may be modified by the Psychologist, with consultation from a NAPPI trainer, to meet the needs of an individual.