HEALTHWEST

Policy and Procedure

No. 06-001

Prepared by:

Effective Date: September 14, 1994
Revised Date: December 12, 2023

Pamela Kimble LMSW, LBA, BCBA
Behavior Treatment Plan Review Committee Chairperson

Approved by:

Subject: Behavior Treatment Plan Review Committee

DocuSigned by:
Rich Francisco
Rich Francisco
Executive Director

I. POLICY:

HealthWest 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 individuals' environment. These strategies will be the least restrictive and will provide a mechanism by which treatment for behavioral concerns are systematically and thoroughly reviewed. We will not employ the use of aversive techniques, seclusion or restraint as defined by the Michigan Department of Health and Human Services (MDHHS).

II. PURPOSE:

To review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. Ensure that all Behavior Treatment 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 HealthWest.

IV. DEFINITIONS:

APPLIED BEHAVIOR ANALYSIS: 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: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular 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 are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purpose of this technical requirement. Use of aversive techniques is prohibited without MDHHS review and approval.

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 "function" of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a physician, physician assistant, or nurse practitioner to identify biological or medical factors related to the target 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 target behavior so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.

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.

IMMINENT RISK: An event/action that is about to occur which will likely result in potential harm to self or others.

INTRUSIVE TECHNIQUES: Those techniques that encroach upon the bodily integrity or the personal space of the individual**,** for the purpose of achieving management or control of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control, or extinguish an individual's behavior, or restrict the individual's 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 Behavioral Treatment Committee (BTC).

PHYSICAL MANAGEMENT: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact despite the individual's resistance 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 individual and staff, an agency shall designate emergency physical management techniques to be utilized during emergency situations. The term "physical management" does not include briefly holding an individual 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 person's respiratory process for behavioral control purposes, is prohibited under any circumstances.

POSITIVE BEHAVIOR SUPPORT (PBS): A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, teaching new skills, and making changes in a person's environment. PBS combines valued outcomes, behavioral, and biomedical science, validated procedures, and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction. PBSs are most effective when they are implemented across all environments, such as home, school, work, and in the community.

PROTECTIVE DEVICE: A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device, as defined in this subdivision and incorporated in written IPOS, shall not be considered a restraint as defined below.

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

PSYCHOTROPIC DRUG: Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.

REQUEST FOR LAW ENFORCEMENT INTERVENTION: 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 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 a licensed hospital.

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 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); and using the Craig (or veiled) bed or any other limitation of the freedom of movement of an individual**.** The 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 MDHHS, a hospital licensed by the MDHHS, 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, the legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the consent of the individual, guardian or parent of 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 of the Mental Health Code.

V. PROCEDURE:

A. The organization of the committee shall include:

1. The Committee shall be comprised of at least three individuals, as appointed by the Executive Director, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual (MPM), Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights (ORR) shall participate on the Committee as ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

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

3. The Behavior Treatment Committee Chairperson reports to the appropriate Quality Council Committee as designated by the Executive 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 Treatment Committee. Committee findings are included in the agency's Quality Improvement Plan.

B. Committee Standards:

a. Establish a time frame specific to each approved plan for re-examination of the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition or when the individual requests the review as determined through the person-centered planning (PCP) process. Such a time shall be no more than one hundred and twenty (120) days. Plans with intrusive or restrictive techniques require minimally, a ninety (90) days review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review, if deemed necessary.

b. Meetings will be scheduled monthly, or as needed, and directed by the Chairperson.

c. 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.

d. 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.

e. The Chairperson keeps all Behavior Treatment Committee meeting minutes, and clearly delineates the actions of the Committee.

f. The author of a Behavioral Support Plan shall be a Licensed Psychologist, Limited Licensed psychologist, Licensed Behavior Analysis (LBA), Assistant Licensed Behavior Analyst (ALBA), Licensed Professional Counselor (LPC), Licensed Masters Social Worker (LMSW), or Limited Licensed Master Social Worker (LLMSW) with training in behavior analysis. The author will abstain from decision making when presenting their own plans.

g. Plans that are reviewed by the committee must be accompanied by:

    i. Results of assessment to rule out physical, medical, and environmental causes of the challenging behavior.
    ii. A functional behavior assessment
    iii. 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.
    iv. Evidence of the kinds of positive supports or interventions already utilized, including amount, scope, and duration of those interventions.
    v. Evidence of continued efforts to find other options.
    vi. Reference to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan is the best option.

h. Each behavior plan reviewed by the committee includes:

    i. Goal – expected outcome of the Behavior Treatment Plan
    ii. Objectives – baseline and steps to achieving the behavior goal
    iii. Methodology – interventions implemented to decrease target behaviors, a schedule and/or timing and things to be done to increase additional adaptive behaviors
    iv. Measurement – how the baseline will be established, what is being measured, and assessment of the impact of behavior treatment interventions on the individual
    v. Plan Review – frequency of reviewing collected data
    vi. Time Frame - When the plan will be implemented
    vii. Staff responsible – who will train the plan, who will implement the plan, and who will monitor/manage the plan

i. The author of the plan shall ensure that all responsible staff are in-serviced prior to implementation of the plan. This training will be documented on the IPOS In-Service Form attached to the current IPOS for which the behavior plan goals/objectives are

outlined. Compliance with training will be monitored by the author's supervisor and by using the peer chart review process.

C. The functions of the Behavior Treatment Committee shall be to:
   a. Review and approve (or disapprove), intrusive and/or restrictive Behavior Plans requiring informed consent by the recipient/guardian on a minimum of a quarterly (90 days) basis.
   b. Be familiar with all litigation involving the use of behavior analysis in the public mental health system.
   c. Review and recommend action regarding current and draft policies on agency behavior support and technology.
   d. Review and recommend action regarding agency research affecting (on or for) individuals we serve.
   e. Design and implement agency training in Applied Behavioral Analysis.
   f. 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:
      i. Dates and the number of interventions used.
      ii. The settings (e.g., individual's home or work) where behaviors and interventions occurred.
      iii. Observations about any events, setting, or factors that may have triggered the behavior.
      iv. Behaviors that initiated the techniques.
      v. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
      vi. Description of positive behavioral supports used.
      vii. Behaviors that resulted in termination of the interventions.
      viii. Length of time of each intervention.
      ix. Staff development and training and supervisory guidance to reduce the use of these interventions.
      x. Ensure that if physical management or use of law enforcement is used more than three (3) times in a thirty (30)-day period, the plan is revisited and modified accordingly if needed.
   g. The committee's effectiveness will be evaluated by stakeholders, including individuals with plans, family and advocates at least yearly.

C. In addition, the Committee may:

1. Advise and recommend to the agency the need for specific staff or home specific training in positive behavioral supports, other evidence based and strength-based models and other individual-specific interventions.

2. Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk or harm.

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

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. Provide specific case consultation as requested by professional staff.

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

VI. REFERENCES AND LEGAL AUTHORITY:

A. The Michigan Mental Health Code. Public Act 258, of 1974.
MCL 330.1700, Michigan Mental Health Code
MCL 330.1704, Michigan Mental Health Code
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MCL 330.1744, Michigan Mental Health Code

B. MDHHS Technical Requirement for Behavior Treatment Plan Review Committees, Last Revision Date: July 20, 2020.

C. MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)

D. CARF Standards

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

I. 1973 PA 116, MCL 722.111 to 722.128.