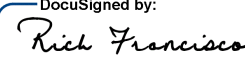




<b>Policy/Procedure Title:</b> Behavior Treatment Plan Review Committee (BTPRC)	<b>Policy and Procedure #: 06-001</b>	<u><b>Review Dates</b></u>	
<b>Category:</b> Clinical  <b>Subject:</b> BTPRC Technical Requirements	<b>Prepared by:</b> Name: Aimee Howard M.S., LBA, BCBA Behavior Treatment Plan Review Committee Chair Title: Board Certified Behavior Analyst  <b>Approved by:</b> DocuSigned by:  AA7EBD48ABB04A3 Rich Francisco, Executive Director	05/06/2026	
	<b>Effective Date:</b> September 14, 1994	<b>Last Revised Date:</b> June 25, 2025	

I. POLICY

Any limitations of the recipient’s rights, any intrusive treatment techniques, or any use of psychoactive drugs for behavior control purposes shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC).

Any limitations of the recipient’s rights, any intrusive treatment techniques, or any use of psychoactive drugs where the target behavior is due to active symptoms of a substantiated serious mental illness or serious emotional disturbance as defined in Sec. 100d of PA 258 of 1974 does not require review and approval by the BTPRC.

All limitations on recipient’s rights shall be justified, time-limited, and clearly documented in the Individual Plan of Service (IPOS). Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what systematic actions will be taken as part of the IPOS to ameliorate (improve) or eliminate the need for the limitations on recipient rights in the future.

Please reference the Home and Community Based Services (HCBS) chapter in the Medicaid Provider Manual for additional IPOS documentation requirements related to limitations.

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. BEHAVIOR TREATMENT PLAN (BTP) STANDARDS:

A. If it is determined through assessment and evaluation that an individual may benefit from an individualized BTP for the purpose of treating, managing, controlling, or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual and/or others at risk of harm, the public mental health agency shall develop a BTP that meets the following criteria:

1. Employs positive behavior supports and interventions using applied behavior analysis (ABA) or other evidence-based practices, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches.
2. Considers other kinds of behavior treatment interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions if positive behavior supports and interventions are documented to be unsuccessful.
3. As a last resort, when there is documented evidence that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes interventions that place limitations on the individual's rights, intrusive treatment techniques or the use of psychoactive drugs. These interventions, described herein, shall be reviewed, and approved by the Behavior Treatment Plan Review Committee (BTPRC) prior to implementation.

B. The person-centered planning process used in the development of a written IPOS will identify when a BTP needs to be developed and where there is documentation that functional behavior assessments as defined in this policy have been conducted to rule out physical, medical, or environmental causes of the target behavior. If any limitations on rights or intrusive techniques are utilized there is documented evidence that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

C. Behavior Treatment Plans must be developed through the person-centered planning process and written consent 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 BTP that includes limiting or intrusive interventions. Behavior Treatment Plans are not effective or ethical if developed without consent or understanding of the participant.

D. The use of aversive techniques, restraint, or seclusion are prohibited from being included in the BTP and shall be disapproved by the BTPRC.

E. Utilization of physical management or requesting law enforcement in an emergency 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.

F. Behavior Treatment Plans that are forwarded to the BTPRC for review shall be accompanied by:

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

2. A functional behavior assessment as defined in this policy.
3. Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to limiting or intrusive techniques at high risk of death, injury, or trauma.
4. Documented evidence of the kinds of positive behavioral supports or interventions, including their amount, scope, and duration that have been used to ameliorate (improve) the behavior within the last 12 months, and have proved to be unsuccessful.
5. Documented evidence of continued efforts to find other options.
6. Practice guidelines that support the proposed use of limiting or intrusive techniques.
7. References to peer reviewed literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the BTP is the best option available. Citing of common procedures that are well researched and utilized within most BTPs is not required.
8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s). The BTP must include who will provide the training and how it will be monitored for fidelity and modifications, if needed.

G. Physical management, and requests for involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the Quality Assessment and Performance Improvement Programs (QAPIP) standards and must be evaluated by the PIHPs QAPIP or the CMHSPs Quality Improvement Project (QIP), and be available for MDHHS review. Any injury or death that occurs from the use of any BTP, physical management, restraint or seclusion is considered a sentinel event. For HealthWest and its contracted providers, only physical management or requests for law enforcement may be used in such emergency situations. Restraint or seclusion should never be used.

V. BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE (BTPRC) STANDARDS:

A. The purpose of the BTPRC is to review and approve or disapprove any BTP that proposes to use limiting or intrusive interventions, as defined in section IV. The BTPRC shall incorporate the standards herein, including those for its composition and functions.

1. HealthWest shall have a BTPRC to review and approve or disapprove of any BTP that proposes to use limiting or intrusive interventions. A psychiatric hospital or psychiatric unit, licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own BTPRC must also have access to and use of the services of the CMHSP BTPRC regarding a BTP for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the BTPRC to a contracted mental health service provider, the CMHSP must monitor that BTPRC to assure compliance with these standards.
2. The BTPRC shall be comprised of at least three (3) individuals, one (1) of whom shall be a licensed behavior analyst, and/or licensed psychologist, if the behavior analysis services provided by the psychologist are within their education, training, and experience; and at least one (1) member shall be a 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 BTPRC as ex-officio, non-voting member to provide consultation and technical assistance to the BTPRC.

3. The BTPRC shall meet as often as needed, based upon the individual's needs.
4. The BTPRC shall review expedited plans within 48 hours of submission. Expedited plan reviews may be requested when, based on data presented by the author of the BTP, it requires immediate implementation. All expedited plan submissions should be submitted to the committee chair, psychologist, and ORR. If any or all other members are not available to review such plan, the BTPRC Chair may receive, review, and approve such plans on behalf of the BTPRC. The ORR must be informed of the proposed BTP to assure that any potential rights issues are addressed prior to implementation. Upon approval, the BTP may be implemented. All BTPs approved in this manner must be subject to full review at the next regular meeting of the BTPRC.
5. The BTPRC shall keep all its meeting minutes and clearly delineate the actions of the BTPRC.
6. A BTPRC member who has prepared a BTP to be reviewed by the BTPRC shall recuse themselves from the final decision-making.

B. The functions of the BTPRC shall be to:

1. Disapprove any plan that proposes to use aversive techniques, physical management, seclusion, or restraint.
2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all BTPs proposing to utilize limiting or intrusive techniques.
3. Determine whether causal analysis of the behavior has been performed; whether positive behavior supports and interventions have been adequately pursued; and, where these have not occurred, disapprove of any proposed BTP utilizing limiting or intrusive techniques.
4. For each approved BTP, set and document a date to re-examine 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 process. BTPs with limiting or intrusive interventions require minimally a quarterly review.
5. Assure that the causal analysis has ruled out any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to limiting or intrusive techniques.
6. Once a decision to approve a BTP has been made by the BTPRC and consent has been obtained from the individual, the legal guardian, the parent of a minor or a designated patient advocate, the BTP becomes part of the individual's written IPOS. The individual, legal guardian, parent 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 plan. The only exception for consent is when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
7. On a quarterly basis track and analyze the use of all physical management, restraint, seclusion, and involvement of law enforcement for emergencies as well as:
  - a. Dates and numbers of interventions used.

- b. The settings (e.g., individual’s home or work) where behaviors and interventions occurred.
  - c. Observations about any events, settings, or factors that may have caused 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 behavior 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.
  - g. Review and modification or development, if needed, of the individual’s BTP.
8. In addition, the BTPRC may:
- a. Advise and recommend to the agency the need for specific staff or home-specific training in positive behavior supports, other evidence based and strength-based models, and other individual-specific nonviolent interventions.
  - b. Advise and recommend to the agency acceptable physical management techniques to be used in emergency or crisis situations.
  - c. At its discretion, review other formally developed BTPs, including positive behavior supports and interventions.
  - d. Advise the agency regarding administrative and other policies affecting BTPs and evidence-based practices.
  - e. Provide specific case consultation as requested by staff of the agency.
  - f. Serve another service entity (e.g., subcontractor) by agreement with involved parties.

VI. DEFINITIONS

TERM	DEFINITION
Applied Behavior Analysis (ABA)	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 and teaching new skills and making changes in an individual's environment. Positive behavior support 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 Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.
Anatomical support	Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient’s physical functioning.
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 individual or would have a specific unpleasant

	effect on a particular individual) by staff to a recipient to achieve the management and 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 BTP and that 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.
Bodily function	The usual action of any region or organ of the body.
Emotional harm	Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
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 that is witnessed and documented by someone other than the service provider.
Facility	A residential facility for the care or treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability that is either a state facility or a licensed facility. Facility includes a preadmission screening unit established under section 409 that is operating a crisis stabilization unit.
Functional Behavior Assessment (FBA)	<p>An FBA is a process to identify target behavior and develop a plan to encourage positive behavior. The FBA process must be completed by a Licensed Behavioral Analyst (LBA) or qualified psychologist and typically consists of the following steps:</p> <ol style="list-style-type: none"> <li>a. Define the target behavior</li> <li>b. Gather and analyze the information</li> <li>c. Identify causal factors or reasons for the behavior</li> <li>d. Develop a hypothesis of the behavior</li> <li>e. Test the hypothesis</li> <li>f. Create a plan of action</li> </ol> <p>A physical examination may be necessary 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 itself 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.</p>
Emergency Interventions	Emergency interventions can only be implemented in a crisis situation when all other supports and interventions fail to reduce the imminent risk of harm. Each agency shall have protocols specifying what emergency interventions and physical management techniques are approved for use. All interventions

	<p>must comply with chapter 7 of the mental health code and associate administrative rules. HealthWest is only permitted to utilize the following emergency interventions:</p> <ul style="list-style-type: none"> <li>a. That are trained and approved</li> <li>b. Request for law enforcement</li> </ul>
Imminent Risk	An event/action that is about to occur that will likely result in serious physical harm to oneself or others.
Functional Behavior Assessment (FBA)	An FBA is a process to identify target behavior and develop a plan to encourage positive behavior. The FBA process must be completed by a Licensed Behavioral Analyst (LBA) or qualified psychologist and typically consists of the following steps:
Individualized Plan of Service (IPOS or plan)	A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.
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 an 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 or control an individual's behavior or restrict the individual's freedom of movement and is not standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires review and approval by the BTPRC.
Limiting 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 as limiting are prohibiting communication with others when that communication would be harmful to the individual; access to personal property when that access would be harmful to the individual; or any limitation of the freedom of movement of an individual for behavioral control purposes. Use of any intrusive techniques for behavior control purposes requires the review and approval of the BTPRC.
Medical and dental procedures restraints	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 shall only be used as specified in the written IPOS for medical or dental procedures.
Person-centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
Physical management	A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: 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, each agency shall designate emergency physical management techniques to be utilized during emergency situations.
Practice or Treatment Guidelines	Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
Prone immobilization	Physical management of an individual in a face down (prone) position, usually on the floor, where force is applied to his/her body in a manner that prevents him/her from moving out of the prone position for the purpose of control. Note: <b>PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES.</b>
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 the written IPOS shall not be considered a restraint as defined below. Use of protective devices/physical barriers to prevent a recipient from causing serious self-injury associated with documented and/or frequent incidents of behavior requires BTPRC review and approval. (See Section IV. Behavior Treatment Plan Standards, for all required elements)
Provider	The MDHHS, HealthWest, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents.
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 seriously aggressive, self-injurious, or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance <b>only when</b> : 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	The use of physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
Seclusion	The temporary placement of a recipient in a room alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital 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.
Serious emotional disturbance	A diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and

	<p>Statistical Manual of Mental Disorders published by the APA and approved by the MDHHS and has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:</p> <ul style="list-style-type: none"> <li>a. A substance use disorder.</li> <li>b. A developmental disorder.</li> <li>c. A "V" codes in the Diagnostic and Statistical Manual of Mental Disorders.</li> </ul>
Serious mental illness	<p>A diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the APA and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one (1) or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:</p> <ul style="list-style-type: none"> <li>a. A substance use disorder.</li> <li>b. A developmental disorder.</li> <li>c. A "V" code in the Diagnostic and Statistical Manual of Mental Disorders.</li> </ul>
Physical management	<p>A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: 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, each agency shall designate emergency physical management techniques to be utilized during emergency situations.</p>
Serious physical harm	<p>Physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.</p>
Support Plan	<p>A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.</p>
Therapeutic de-escalation	<p>An intervention, the implementation of which is incorporated in the written IPOS, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.</p>

Time out	A voluntary response to the therapeutic suggestion to a recipient to remove himself/herself from a stressful situation to prevent a potentially hazardous outcome.
Unreasonable force	<p>Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:</p> <ul style="list-style-type: none"> <li>a. There is no imminent risk of serious or non-serious physical harm to the recipient, staff, or others.</li> <li>b. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.</li> <li>c. The physical management used is not in compliance with the emergency interventions authorized in the recipient's written IPOS.</li> </ul> <p>The physical management or force is used when other less restrictive measures were possible, but not attempted, immediately before the use of physical management or force.</p>

VII. LEGAL REFERENCES AND AUTHORITIES

1. 1973 PA 116, MCL 722.111 to 722.128.
2. 1997 Federal Balanced Budget Act at 42 CFR 438.100
3. MDHHS Administrative Rule 7001(l)
4. MDHHS Administrative Rule 7001(r)
5. MDHHS Administrative Rule 7199(2)(g)
6. CARF Standards
7. The Michigan Mental Health Code:
  - a. Public Act 258, of 1974. 1974
  - b. MCL 330.1700
  - c. MCL 330.1704
  - d. MCL 330.1712
  - e. MCL 330.1740
  - f. MCL 330.1742
  - g. MCL 330.1744
8. MDHHS Technical Requirement for Behavior Treatment Plan Review Committees, Last Revision Date: Dec 12, 2023

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