

SUBJECT Behavior Management Review		CHAPTER 01	SECTION 04	SUBJECT 04
CHAPTER Administrative		SECTION Quality Management		
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A. APPLICATION:

- PIHP Board CMH Providers SUD Providers
 PIHP Staff CMH Subcontractors

B. POLICY STATEMENT:

It shall be the policy of the Region 10 PIHP to ensure the review and approval/disapproval of treatment plans proposing to utilize restrictive or intensive interventions occurs for the network.

C. DEFINITIONS:

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 substances to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. 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 (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is **prohibited**.

Behavior Management Review Committee: A specially constituted body that is designed to review, approve or disapprove proposed behavioral treatment plans. The BMC is comprised of at least three individuals; one member shall be a fully or limited-licensed psychologist and one member shall be a licensed physician/psychiatrist.

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 that is not a standard treatment or dosage for the individual’s condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Imminent Risk: An event/action that is about to occur that will likely result in the potential harm to self or others.

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Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in 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. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. 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 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 Supports (PBS): A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injuries or other behaviors by conducting a functional assessment and by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction and pica. PBS are most effective when they are implemented across all environments.

Practice or Treatment Guidelines: Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the Federal government.

Restraint: The use of any physical or mechanical device to restrict an individual's movement at the order of a physician. This definition excludes anatomical or physical supports or protective devices. The definition also excludes safety devices required by law, such as car seat belts or child car seats used while riding in vehicles. 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 ordinary access to food; 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.

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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 special consent of the recipient, guardian or parent of a minor recipient may only occur when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

D. STANDARDS:

Reference should be made to the most recent MDHHS contract attachment technical requirements in this area.

BEHAVIOR MANAGEMENT REVIEW COMMITTEE

1. Each CMH shall have a Behavior Management Review Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMH and does not have its own Committee must also have access to and use the services of the CMH Committee regarding a behavior treatment plan for an individual receiving services from that CMH. If the CMH delegates the functions of the Committee to a contracted mental health service provider, the CMH must monitor that Committee to assure compliance with this technical requirement.
2. The Committee shall be comprised of at least three individuals, one of whom shall be a licensed Psychologist as defined in Section 2.4 in the Medicaid Provider Manual with the specified training and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.11 00c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other nonvoting members may be added at the Committee's discretion, and with the consent of the individual whose treatment plan is being reviewed.
3. The Committee members, including the Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms.
4. The Committee shall meet as needed.
5. The Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.

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6. The Committee shall keep all its meeting minutes and clearly delineate the actions of the Committee.
7. The Committee shall ask that a Committee member who has prepared a behavior treatment plan to be reviewed by the Committee recuse themselves from the final decision-making.
8. The functions of the Committee shall be to:
 - a. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
 - b. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
 - c. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
 - d. For each approved plan, 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. Plans with more intrusive or restrictive techniques require minimally a quarterly review.
 - e. Assure that inquiry has been made about any medical, psychological or other factors that the individual has might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
 - f. Arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, 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. (MCL 330.1712 [2])
 - g. On a quarterly basis, track and analyze the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the

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intervention, as well as:

- I. Dates and numbers of interventions used.
- II. The settings (e.g., group home, day program) where behaviors and interventions occurred
- III. Observations about any events, settings 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. Review and modification or development, if needed, of the individual's behavior plan.

9. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program (QAPIP) and be available for MDHHS review. Physical management, and/or involvement of law enforcement permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported by the Committee to the QAPIP. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event that must be reported to the PIHP.

10. In addition, the Behavior Management Review Committee may:

- a. Advise and recommend to the agency the need for specific staff training in positive behavioral Supports, and other individual-specific non-violent interventions.
- b. 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.
- c. 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.
- d. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
- e. Provide specific case consultation as requested by professional staff of the agency.

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- f. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
- g. Serve another service entity (e.g., subcontractor), if agreeable between the involved parties.
- h. All decisions by the committee shall require a majority of those approving members present.
- i. Approvals, modifications and denials of any behavioral treatment plan must be documented in the official BMC minutes. Minutes of each committee meeting shall be maintained and distributed as quarterly reports to the PIHP.

BEHAVIOR TREATMENT PLAN STANDARDS

1. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the behavior.
2. Behavior treatment plans must be developed through the person-centered planning process and written special 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 behavior treatment plan that includes intrusive or restrictive interventions.
3. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law, shall be disapproved by the Committee.
4. Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30 day period, the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS and DHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.
5. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.
6. Plans that are forwarded to the Committee for review shall be accompanied by:

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- a. Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
- b. A functional behavioral assessment.
- c. 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.
- d. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
- e. Evidence of continued efforts to find other options.
- f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
- g. References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available.
- h. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

V. PROCEDURES: N/A

VI. EXHIBITS:

A. BMC Quarterly Report Form

CMH Behavior Management Committee Quarterly Report

CMH: _____

CMH BMC Contact Person: _____

Report Period () First Quarter () Second Quarter () Third Quarter () Fourth Quarter

- 1. Number of BMC Meetings _____
- 2. Number of Committee Minutes attached _____
- 3. Number of Total Case Charts reviewed _____
- 4. Number of Case Charts / Behavior Plans reviewed utilizing:
 - A. Aversive techniques, only _____
 - B. Restrictive techniques, only _____
 - C. Intrusive techniques, only _____
 - i. psychotropic medication for treatment of behavioral symptoms _____
 - ii. psychotropic medication for treatment of DSM-IV diagnoses for individuals with DD _____
 - iii. other _____
 - D. Token economies with response cost _____
 - E. Two or more of the above (A, B, C, D) _____
 - F. Utilization of Positive Behavior Supports _____
- 5. Number of Case Charts / Behavior Plans:
 - A. 4 A – D Approved _____
 - B. 4 A – D Approved per Contingencies (e.g. culture of gentleness, proactive/reactive strategies, PBS / PBS Training) _____
 - C. 4 A – D Denied _____
 - D. 4 F Approved _____
 - E. 4 F Approved with Contingencies _____
- 6.* Number of Reviews regarding:
 - A. Adverse Incidents _____
 - B. Lethal Cases _____

*These reviews may be completed by another Administrative Review process as determined by the CMH CEO

CMH BMC Chair _____

Date _____