I. PURPOSE: To establish policies and procedures which guide the application and oversight of behavior treatment.

II. APPLICATION: Programs operated by or under contract or agreement with Community Mental Health for Central Michigan.

III. REFERENCE:

A. Michigan Mental Health Code
B. Michigan Department of Community Health Administrative Rules
C. Comprehensive Accreditation Manual for Behavioral Health Care, The Joint Commission, PC.10.10-PC.10.130
D. Michigan Department of Community Health Technical Requirement for Behavior Treatment Plan Review Committees
E. MDCH Medicaid Provider Manual 3.3 Behavioral Management Review

IV. DEFINITIONS:

A. 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, 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 positive behavior support 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 policy. Otherwise, use of aversive techniques is prohibited.
B. BLOCKS	Defensive techniques used by staff to protect themselves when individuals hit or throw things at them. Blocks are the least restrictive of the physical intervention techniques and must be used in conjunction with non-physical intervention strategies such as Confrontation Avoidance, De-escalation and Communication skills.
C. COME-ALONGS	Come-Alongs are techniques used to assist in transporting or regaining self-control. Come-Alongs enable staff to safely move individuals while exerting only the amount of control required by the situation. They can be either very restrictive or very non-restrictive. In its simplest form a Come-Along can be

	used to provide gentle helpful guidance to an individual who is disoriented or has difficulty walking. If necessary, however, the basic Come-Along position allows staff to quickly become more restrictive when interacting with individuals who must move but do not want to move.
D. HANDS DOWN	A release technique not intended to be a physical hold. This is used when an individual is flailing or attempting to self-abuse. Staff hands are used to shadow the movements of the individual or to offer light touch without applying pressure. Hands Down must be used in conjunction with non-physical intervention strategies such as Confrontation Avoidance, De-escalation or Communication Skills.
E. 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 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.
F. NON-PHYSICAL INTERVENTION	Strategies that promote a culture of gentleness and teach staff to help an individual calm before a situation escalates. Use of these techniques is required prior to implementing physical intervention. Different techniques will be used depending on the situation, but staff should be consistent in their actions. The techniques include Pro-Active Options, Communication Skills, Confrontation Avoidance, and De-escalation. They should be used regularly and naturally during interactions with individuals who display challenging behaviors.
G. PEER-REVIEWED LITERATURE	Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

H. 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 will only by used on an emergency basis when the situation places the individual or others at imminent risk of physical harm. Physical management, as defined here, will not be included as a component of a positive behavior support 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 for behavioral control purposes is prohibited under any circumstances.
I. POSITIVE BEHAVIOR SUPPORT	A set of research-based strategies used to increase quality of life and decrease problem behavior 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 problem behaviors such as self-injury, aggression, property destruction, pica, defiance, and disruption.
J. PRACTICE OR TREATMENT GUIDELINES	Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
K. PRONE IMMOBILIZATION	Extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to the individual's body in a manner that prevents him or her from moving out of the prone position.
L. RESTRAINT	The use of a physical or mechanical device used 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. This definition excludes • Anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning • Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a positive behavior support plan which has been reviewed and

approved by the Committee and received special consent from the individual or his/her legal representative.
- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

M. 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 prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; 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 Behavior Treatment Committee.

N. 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.

O. 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 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.

P. STANDING WRAPAROUNDS

A restrictive technique for controlling an individual's activity. It is the most restrictive technique and should only be implemented when all other interventions have failed. Standing Wraparound should not be maintained any longer than necessary to assist the individual in regaining control. Time increases the risk of injury and undesirable side effects. As individuals regain self-control they should be gradually and cautiously released from the Wraparound.

V. POLICY: Behavior treatment interventions will be guided by the following principles and practice.

A. Behavior treatment interventions for unprecedented and unpredicted crises or emergency occurrences of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm will be the least restrictive and least intrusive needed to prevent harm.

B. Positive Behavior Support Plans for non-emergent or continuing occurrences of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm will:
   1. Be based on the assessment of the individual, including strengths and deficits, and on the assessment of the target behaviors, including frequency, duration and intensity.
   2. Rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.
   3. Include in their development input from the individual and their person centered planning team in the selection of behavior treatment interventions and be written into the Person Centered Plan or as an addendum to the PCP.
   4. Be implemented across all environments or rationale given for why that is not appropriate.
   5. Be designed, supervised, monitored, changed or discontinued only by persons who have qualifications, training, experience and knowledge relating to behavior treatment interventions.
   6. Be implemented only by persons who are competent, supervised and trained in how to implement the plan.
   7. If they include restrictive or intrusive interventions, be designed to ameliorate or eliminate the need for such interventions in the future.
   8. Adhere to any legal psychiatric advance directive that is present for an adult with serious mental illness.
   9. Employ positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches.
   10. Consider other kinds of behavior treatment or 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.
   11. As a last resort when there is documentation that neither positive behavior supports and interventions nor other kinds of interventions were successful, propose restrictive or intrusive techniques, described herein, that will be reviewed and approved or disapproved by the Behavior Treatment Committee.

C. Positive Behavior Support Plans that include the use of aversive procedures will not be permitted.

D. Individuals receiving CMHCM services have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

E. Physical management will only be used on an emergency basis when the situation places the individual or others at imminent risk of physical harm and will be documented per agency requirements. Only those techniques approved by CMHCM, Block (not physical management), Hands Down, Come-Along and Standing Wraparound, will be used. Physical management, as defined herein, will not be included as a component of a Positive Behavior Support Plan. When a pattern of behavior indicates emergency physical management is likely to be required on an ongoing basis, the Person Centered Plan for the individual will include a statement that in the event the behavior of the individual puts the individual or others at imminent risk of physical harm staff will use the least restrictive, most effective form of emergency physical management needed to assure the safety of everyone. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances.

F. A Behavior Treatment Committee will:
   1. Be appointed by the Executive Director
   2. Have a minimum of three members.
   3. Have at least one member who is a full or limited licensed psychologist with specified training and experience in applied behavior analysis
   4. Have at least one member who is a licensed physician/ psychiatrist

5. Have at least one clinical representative from services who has expertise in working with people with mental illness and/or people with developmental disabilities.
6. Have a Recipient Rights Officer/Advisor serving as an ex-officio member of the committee.
7. Have two-year overlapping terms for members, who may be reappointed to consecutive terms.
8. At the discretion of the Committee, and with the consent of the individual whose treatment plan is being reviewed, allow participation by other non-voting attendees.

G. The functions of the Behavior Treatment Committee are as follows:
1. Review plans and behavioral data to assure that an intervention is necessary; that the intervention is the least restrictive effective intervention; and that the rights of the individual are protected.
2. Disapprove any Positive Behavior Support Plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
3. Determine whether causal analysis of the behavior has been performed, whether positive reinforcers have been identified and 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.
4. Expeditiously review and approve or disapprove, in light of current peer-reviewed literature or practice guidelines, all Positive Behavior Support Plans proposing to utilize intrusive or restrictive techniques.
5. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review will occur no more than three months from the date of the last review, or more frequently if clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire Positive Behavior Support Plan should be reviewed by the Committee.
6. Assure that inquiry has been made about any 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 intrusive or restrictive techniques.
7. Advise the Executive Director regarding administrative and other policies and practices affecting behavior services, including staff training needs.
8. Arrange for an evaluation of the Committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates.
9. Quarterly track and report to the Performance Improvement Committee the use of all physical management or PRN medication for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
    a. Dates and numbers of interventions used
    b. The settings (e.g., group home, day program) where behaviors and interventions occur
    c. Behaviors that initiated the techniques
    d. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention
    e. Attempts to use positive behavioral supports
    f. Behaviors that resulted in termination of the interventions
    g. Length of time of each intervention
    h. Staff development and training and supervisor guidance to reduce the use of these interventions

H. The Behavior Treatment Committee will meet on a regular basis to review submitted plans that require committee action. If there is a need for emergency approval, two BTC members or one BTC member and one member of the Executive Leadership Team can provide the approval until the next scheduled meeting of the BTC.

I. Two voting members will constitute a quorum.

J. Any Committee member who has prepared a Positive Behavior Support Plan to be reviewed by the Committee will recuse himself/herself from the final decision-making.

K. The Committee will select the chairperson and the chairperson will authorize a designee in their absence.

VI. PROCEDURE:

A. Proposed plans, data and reports for BTC review must be received by the committee chairperson/designee at least five working days prior to the next scheduled meeting.

B. Staff submitting a plan for BTC review will assure that the following information is submitted:
   1. Proposed Positive Behavior Support Plan with attached Positive Behavior Support Plan Summary Form CMHCM-200.
   2. Evidence that the plan was developed as part of the person-centered planning process.
   3. Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
   4. 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.
   5. 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.
   6. Evidence of continued efforts to find other options.
   7. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   8. 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.

C. The following information will be available in the proposed plan.
   1. Purpose of the plan and the target behaviors.
   2. Functional behavioral assessment.
   3. Less restrictive measures that have been tried/justification for restrictiveness.
   4. Goals and objectives.
   5. Positive reinforcement of adaptive/replacement behaviors and schedule utilized.
   6. Maximum time limits for interventions.
   7. Method of data collection.
   8. Baseline data.
   9. Current data.
   10. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

D. If the plan is intrusive or restrictive, guardian approval is required before implementation.

E. Behavior data and reports of progress using approved plans will be submitted to the BTC on the Positive Behavior Support Staff Report Form CMHCM-920 at a frequency determined by the BTC. Use of emergency physical management, emergency PRN medications and approved intrusive or restrictive interventions will be recorded on the Positive Behavior Support Intervention Data Form CMHCM-919, submitted to the assigned case manager and forwarded to the BTC for review and feedback.

F. In order to minimize the possibility of re-traumatization of those who have experienced earlier trauma, staff will be trained in and expected to utilize de-escalation in crisis situations. Plans will include reference to an individual's statement of preference for crisis response.

G. Staff hired as Case Managers, and their Supervisors will have a human service degree. Within 30 days of hire or within 30 days of approval and availability of the materials to those already employed at the agency, all Case Managers, and their Supervisors will read, test, and pass the following three items in the Essential Learning online training system: 1) this policy, 2) the course titled *Principles of Positive Behavior Support for Individuals with Developmental Disabilities*, and 3) the five page article by Developmental Enhancement, PLC (David Laman) titled *Positive Behavior Support*. Successful completion initially of documents #1 and #2, and annually thereafter of #3 is required in order for the supervisor to rate the supervisee as demonstrating competence at behavior services. In addition to the three readings with tests, attendance is required at an annual workshop on a topic related to positive behavior support. Additional readings may be recommended and required by the BTC. De-escalation training will be offered by the CMHCM Training Department to all staff who may encounter individuals

in need of that approach. Additional, in-depth training and positive support plan writing can be provided on an as needed basis through behavioral consultation for particularly challenging situations that have not been impacted by previous positive behavior support plans. Also, strongly encouraged are ongoing discussions in staff meetings and/or in supervision of some aspect of writing positive behavior support plans.

H. Even in emergency situations, staff will only use physical management techniques for which they have been trained. The only exception is that it is not considered unreasonable force to take whatever action is needed to protect an individual from something with a high risk of very serious physical harm, such as running out into traffic.
   1. It is essential that all staff learn how each individual communicates their wants and needs, particularly those whose primary method of communication is non-verbal.
   2. Blocks (not physical management), Hands Down, Come-Along and Standing Wraparound are the techniques approved by CMHCM to be used by staff trained in how to implement them, and only to be used in emergency situations when there is imminent risk of physical harm.
   3. The CMHCM Training Department will offer training to CMHCM staff and to contract providers who will then train their staff. The training will emphasize positive approaches and include de-escalation and confrontation avoidance, as well as how to implement the four approved techniques named in #2.
   4. Records will be kept of who has been trained on what date to implement and/or to train the techniques. Provider trainers will document reviewing the techniques with trained staff every three months. Providers will notify CMHCM when they need additional trainers trained. CMHCM training staff will be available to consult with providers after the initial training.
   5. Case managers will determine before placement whether staff working with a specific individual need to be trained in CMHCM-approved techniques to be used in emergency situations when there is imminent risk of physical harm.

Approved: 10/1/01

Revised: 12/17/02
Revised: 1/25/05
Revised: 3/28/06
Revised: 11/28/06
Revised: 4/13/07
Revised: 1/27/09
Revised: 3/26/09
Revised: 7/23/09
Revised: 3/30/10
Revised: 5/25/10