BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment Services**		
Section: 26	**Behavior Treatment**		
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to implement the Michigan Department of Health and Human Services (MDH) technical requirements on treatment approaches for individuals served in the public mental health system who exhibit problem behaviors. This document is herein incorporated into this policy by reference.

Purpose

This policy and procedure was developed to define the ethics, composition, responsibilities and processes implemented to oversee the proposed use of any intrusive and restrictive interventions that might be considered for usage as described in Behavior Treatment Plans.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Client Services Specialists, Ancillary Care, Clinical Management, Residential Nursing Staff and Direct Care
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Residential Providers
☐ Policy Only ☒ Policy and Procedure
☐ Other:

Background

This policy and procedure establishes technical requirements that must be incorporated into the design and delivery of all mental health services. The Pre-Paid Inpatient Health Plan (PIHP)

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provider and its Community Mental Health Services Program (CMHSP) Affiliates may adopt these guidelines in their entirety or develop local requirements that are consistent with this document.

Definitions

Definitions are written in accordance with the most current MDHHS Technical Requirement for Behavior Treatment Review Committees.

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 the principles of operant and respondent conditioning theory. It also refers to a set of techniques for modifying behavior toward meaningful ends based on these conceptions of behavior. Although this field of study is a recognized sub-specialty in the psychology discipline, not all practitioners are psychologists and such training may be acquired in a variety of disciplines.

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, 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.

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<u>Disclaimer:</u> It is the policy of the PIHP that aversive interventions are prohibited by any direct or contract provider employee.

<u>Behavior Assessment/Functional Behavioral Assessment (FBA):</u> An approach that incorporates techniques and strategies to determine the patterns and purpose or function of a particular behavior and guide the development of an effective and efficient behavior plan. The Assessment will contain a precise description of a person's behavior, its context, and its consequences, with the intent of better understanding the behavior and those factors influencing it. The focus of the FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain or end a behavior. An FBA must occur prior to the establishment of a Behavior Treatment Plan. The behavior assessment/functional analysis addresses the following issues associated with identified target behavior(s): environmental and contextual factors (antecedent, behavior, and consequence) and the individual's skill and/or performance deficits. Additionally, the target behavior(s) is identified and the frequency, duration, and/or intensity of the target behavior(s) is assessed. The assessment provides insight into the function of the behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function to meet the identified need. A physical examination must be done by a MD/DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations.

<u>Behavior Management</u>: The exercise of strategies for the control or treatment of problem behavior to achieve therapeutic objectives through the use of a variety of recognized techniques. Techniques are based on general behavior theory, verbal directions, physical guidance, physical management, and medications. It is the policy of the PIHP region to employ behavior modification treatment techniques rather than behavior management techniques when the technique used is not needed to assure safety.

<u>Behavior Modification:</u> The systematic application of principles of general behavior theory to the development of adaptive and/or elimination of problem behavior consistent with therapeutic objectives. Interventions used for behavior modification include, but are not limited to: applied

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analysis of behavior, schedules of reinforcement, token systems, cognitive therapy, self-control therapy, social skills training, modeling, shaping, fading, generalization, relaxation training, systematic desensitization, stimulus control, positive practice and contingency management.

Behavior Treatment Review Committee (BTRC): A specially-constituted committee whose primary function is to oversee the proposed use of any intrusive and restrictive techniques that might be considered for usage as a last resort with recipients of public mental health services.

Behavior Treatment Plans: Treatment methods encapsulated in a plan written for the purpose of changing targeted behavior through specific behavior modification methods. Behavior treatment is the intervention used with target behavior(s) to achieve therapeutic objectives through the use of a variety of recognized techniques. The terms "Behavior Treatment Program" and "Behavior Treatment Plan" are used interchangeably. All Behavior Treatment Plans are individualized and are based on the results of a Behavior Assessment. Prior to implementation, as appropriate, individuals and/or their family/guardian are educated about, and must agree to participate in, behavior treatment. Those participants will then take part in identifying antecedents to, and consequences of, the target behavior(s) and must agree to the target behavior(s) and treatment interventions before the Behavior Treatment Plan can be put into effect. Behavior treatment plans must be developed through the Person Centered Planning process and be approved 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. Behavior treatment interventions identify, teach, and support the acquisition and reinforcement of identified adaptive/replacement behaviors. Behaviors being treated are assessed to determine that appropriate behavior is exhibited. The organization collects and analyzes data on the use of behavior treatment interventions to monitor and improve treatment efficacy.
Imminent Risk: an event or action that is about to occur that will likely result in the potential harm to self or others.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously

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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 BTRC.

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.

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 for behavioral control purposes is **prohibited under any circumstances.** Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient's body in a manner that prevents him or her from moving out of the prone position.

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

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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.

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

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

Reactive Strategies in a Culture of Gentleness: strategies within a Positive Behavior Support Plan used to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking.

Recipient Rights: Means that a person who receives services from the PIHP region, or an agency or provider under contract with the PIHP region, has the same rights, benefits, and privileges as a person who is not receiving mental health services, including rights guaranteed by the Michigan Mental Health Code (MMHC), except when divested or limited by: a court, statute or rule, and/or voluntary agreement of the recipient or person legally empowered to consent on behalf of the recipient.

Restraint: The use of a 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. This definition excludes:

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- 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 recipient 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 (IPOS) through a Behavior Treatment 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.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the MMHC and the federal Balanced Budget Act (BBA). 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 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 BTRC.

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 MDCH, a hospital licensed by MDCH, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Request for Law Enforcement Intervention: calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a 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 **only when**: caregivers are unable to remove other individuals from the

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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.

Special Consent: Obtaining the written consent of the recipient, 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 IPOS 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 MMHC.

Target Behaviors: Behavior or behaviors that are the focus of treatment in a Behavior Treatment Plan.

Targeted Case Manager (CM)/Supports Coordinator (SC): The designated staff person whose primary function is to plan, coordinate, link and monitor the delivery of services and supports identified in an approved Behavior Treatment Plan.

Procedure

Types of Plans

There are three types of plans that the psychologist may develop to address problem symptoms and behavior.

1. Guidelines for Staff – These are positive support interventions that staff should use to respond to challenging or problem behaviors. Guidelines for Staff do not need to be

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reviewed by the Behavior Treatment Review Committee (BTRC) nor is monitoring by the psychologist required.

2. Positive Support Plan – These plans include only positive support interventions and the psychologist is requesting that the staff record data for the psychologists review. These plans do not require the review, approval and monitoring of the BTRC. The psychologist will monitor data quarterly and revised the plan if needed.
3. Behavior Treatment Plan – These plans include a restrictive or intrusive intervention. and are required to be reviewed by the BTRC at least quarterly or more frequently as determined by the BTRC. The psychologist will monitor the plan at least quarterly or more often based on the needs of the individual.

Interventions in Behavior Treatment Plans Requiring Special Consent:

A. 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 BTRC.

B. Restrictive Techniques: Those techniques that when implemented, will result in the limitation of a recipient's rights as specified in the MMHC and the federal BBA.

C. Other Techniques: Those techniques that accomplish restriction, intrusion, or unpleasant stimulation, although called by another name, and techniques that are insufficiently documented in the established literature, or evidence-based practices, related to behavior management. "Insufficient" means that in the best judgment of the BTRC, there are too few references in commonly available literature. A rough standard entails whether the technique is familiar to appropriately trained colleagues.

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D. Aversive techniques: It is the position of BABHA to prohibit the use of aversive techniques

E. Any restriction or limitation shall be justified, time-limited, and clearly documented in the plan of service.

Requirements For Behavior Treatment Plans

Behavior Treatment Plans shall be written, implemented, and monitored in compliance with PIHP, MDHHS, and federal guidelines and shall incorporate the standards and guidelines defined in this policy. The CMHSP will utilize the least restrictive/intrusive methodology and behavior modification techniques. In all cases, the rights and privileges of the individual (also known as the person/consumer) shall be safeguarded, including the right to safe and effective treatment. A formal written Behavior Treatment Plan is necessary for Level II and Level III procedures. Level II and Level III procedures are defined on pages 10 through 16 of this document. A formal written Behavior Treatment Plan is necessary when medication(s) are given for behavior control and/or for the purpose of behavior management.

Each Behavior Treatment Plan shall specify:

- Goal - expected outcome of the Behavior Treatment Plan.
- Objectives - measurable steps to achieving the expected outcome.
- Methodology - interventions implemented to impact the target behavior(s).
- Measurement - what is being measured, method of data collection, and assessment of the impact of the intervention.
- Plan Review - frequency of reviewing collected data.
- Supervising Clinician - Clinician that in-services and monitors the implementation of the Behavior Treatment Plan.

Standards of Care

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Behavior Treatment Programs shall be reviewed periodically by the BTRC for compliance with this procedure.

A. Behavior Treatment Plan Standards

1. The person-centered planning process used in the development of an IPOS will identify when a Behavior Treatment Plan needs to be developed and where there is documentation that 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 change 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.Recipient Rights standards are to be adhered to in order to support and enforce this policy. Recipients have the right to a thorough habilitation program designed to help them to progress to a less restrictive and less aversive setting.

4. Behavior Treatment Plans shall not include physical management in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law.

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 BTRC.

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

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individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS 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.

6. Staffing ratios and training will be adequate for implementation of the Behavior Treatment Plan. Initial training of the Behavior Treatment Plan will be conducted by the psychologist.

7.Plans that are forwarded to the BTRC for review shall be accompanied by:

i. Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
ii. A functional 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 behavioral supports or interventions, including their amount, scope, and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
v. Evidence of continued efforts to find other options.
vi. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
vii. 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.
viii. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

Behavior Modification Procedures Not Requiring Behavior Treatment Approval:

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Behavior treatment programs are to be directed toward maximizing the growth and development of the individual by incorporating the hierarchy of available procedures that emphasize positive approaches. Positive reinforcement tends to be most successful when programs are developed around an individual's needs and demonstrated abilities. The following strategies are preferred. These procedures do not require authorization by any administrator, the person receiving services, guardian or behavior treatment review committee.

A. Behavior Chains: A sequence of stimuli and responses that end with terminal behavior, such as forward chaining, backward chaining, and total task chaining.
   1. Forward Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in a series of steps from the initial step in the sequence to the final step.
   2. Backward Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in a series of steps from the final step in the sequence to the initial step.
   3. Total Task Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in all steps simultaneously.

B. Differential Reinforcement: The delivery of reinforcement after an appropriate behavior, and/or incompatible behavior other than the target behavior, is displayed, resulting in the decrease of the target behavior. Types of differential reinforcement procedures are described below.
   1. Differential Reinforcement of Other Behavior(s) (DRO) is a procedure where any behavior other than the target behavior is reinforced on a periodic schedule.
   2. Differential Reinforcement of Alternative Behavior(s) (DRA) is a procedure where an alternative or competing behavior to the target behavior is reinforced on a periodic schedule.

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3. Differential Reinforcement of Incompatible Behavior(s) (DRI) is a procedure where a behavior that cannot be emitted at the same time as the target behavior is reinforced on a periodic schedule.
4. Differential Reinforcement of Low Rates of Behavior(s) (DRL) is a procedure where the infrequent occurrence (rate) of a target behavior is reinforced.
5. Differential Reinforcement of High Rates of Behavior (s) (DRH) is a procedure where the frequent occurrence (rate) of a target behavior is reinforced.

C. Extinction: The systematic elimination of potential reinforcement following a particular behavior. This is often accomplished by staff pretending that a behavior did not occur by ignoring it.

D. Fading: The gradual change of the stimulus control. Fading is used to foster independence by eliminating control that prompts have had over a person's behavior.

E. Instructional Control: The delivery of information about the correctness/appropriateness or incorrectness/inappropriateness of a person's behavior. Such instructions may be effected through manual guidance of the person through the correct response, a prompt or verbal statement such as "yes", "no", "correct", or "wrong". Instructional control is not considered restrictive.

F. Interruption: The use of a verbal cue to break in upon an action, e.g. "Please, Stop! You may not spit on the floor."

G. Low Stimulation: An individual's voluntary response to the therapeutic suggestion to remove himself/herself from a stressful situation in order to prevent a potentially hazardous or undesirable outcome.

H. Non-contingent Reinforcement: The delivery of a reinforcer that is not dependent upon the occurrence or non-occurrence of a target behavior.

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I. Positive reinforcement: The presentation of a stimulus or occurrence of an event, contingent upon a specific response, that results in an increase of the frequency of occurrence of the response.

J. Prompting: An additional discriminative stimulus that is presented in order to cue the person to perform a specified behavior. Prompts may be verbal, gestural, or involve physical guidance.
   1. Verbal prompts are defined as oral sounds or sign language signs presented to a person to cue performance of a specific task.
   2. Gestural prompts are defined as pointing, hand movements or other body movements presented to a person to cue performance of a specific task.
   3. Physical prompts are defined as non-restrictive physical contacts with a person, using no significant physical pressure, to cue performance of a specific task.

K. Redirection: An initial verbal prompt, which may be paired with a physical prompt that guides the individual to the appropriate activity.

L. Reinforced Practice: A procedure whereby a person is afforded many opportunities to practice and receive reinforcement for practicing a behavior in his/her repertoire to insure the behavior is learned.

M. Shaping: The process of differentially reinforcing successive approximations (small steps) toward the desired level of behavior until the behavioral sequence is fully achieved.

N. Stimulus Change: The altering of stimuli to create a situation so different from that which previously existed that the ongoing behavior is temporarily suppressed.

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O. Other Voluntary Techniques: The following commonly accepted practices, while not an exhaustive list, are also included to illustrate additional procedures not requiring administrator, person receiving services, guardian or other approving authority.

1. Anger Management Techniques/Calming Strategies/Self-Control Activities and Exercises
2. Social Skills Training
3. Structured Social/Activity Involvement
4. Daily Positive Interaction Time (with parent or staff member)
5. Daily/Weekly Outings or Other Rewards (beyond what is specified in the person's Person Centered Plan (PCP))
6. Problem Solving Discussions
7. Structured Relaxation Training
8. Suggested Relaxation
9. Teach/Train Positive Activity with Property (for individuals who exhibit property damage)
10. Nighttime Bed Checks for Enuresis/Encopresis (Toileting Schedule)
11. Behavioral Contracting/Contingency Contracting
12. Visual Demonstration of Personal Space (arm's length away)
13. Compliance Training
14. Sensory Stimulation – utilizing an alternative stimulus for the purpose of redirection (e.g., a client who engages in finger-flicking is given object to hold/wear of certain texture, color, size)
15. Structured Alone Time
16. Daily Journaling
17. Encourage Incompatible Behavior as Targeted Behavior Occurs

4. Behavior Modification Procedures Requiring Behavior Treatment Review Committee Approval:

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There are times when a person's behavior seriously impedes the possibility for reasonable growth; (i.e., the behavior presents a risk to the person, other persons, or otherwise interferes with the learning process). If positive approaches are not successful in sufficiently promoting desirable behaviors, restrictive techniques may be a reasonable therapeutic approach. Under such conditions, these procedures may not only be necessary, but may represent the only viable way to make available the person's right to habilitation. Consistent with this rationale, the CMHSP supports the use of such interventions. In all cases, a hierarchy of least restrictive techniques will be followed. Restrictive interventions are to be used in conjunction with a total program effort, which should emphasize positively reinforcing program strategies.

Written informed consent by the person or the person's guardian is required for all of the following interventions prior to implementation. Behavior Treatment Plans must be developed through the PCP process and be approved 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. The BTRC shall review authorized the interventions in writing before they may be implemented. After approval, the BTRC will monitor plans at least quarterly at a BTRC meeting.

A. Negative Practice: A procedure in which a person, behaving inappropriately, is required to repeatedly practice the inappropriate behavior in order to reduce that behavior.

B. Positive Practice: A procedure requiring a person to repeatedly practice a desirable behavior following the occurrence of an inappropriate behavior. For example, the person is required to practice asking for help instead of throwing work materials.

C. Response Blocking for Self-injurious Behavior: A procedure where a person, acting as a change agent, blocks the movement of a person receiving services to prevent a potentially injurious behavior from occurring. For example: a staff person may block the arm of a person, who demonstrates head-hitting behavior, to prevent contact between the person's hand and head.

D. Response Cost: The response-contingent removal of a positive reinforcer. A previously earned reinforcer or access to personal property may be removed.

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E. Restoration/Restitution/Overcorrection**:** The teaching of a person to assume responsibility for the disruption of an environment caused by his/her maladaptive behavior by requiring the person to restore the environment to a condition as good as or better than that which existed prior to the person's display of the maladaptive behavior.

F. Satiation: Refers to the reduction in effectiveness of a reinforcer after an excessive amount of it has been presented. This procedure may apply when unlimited amounts of a reinforcer, that has maintained an unacceptable response, is presented non-contingently in order to reduce targeted behavior(s).

G. "Therapeutic De-escalation": An intervention, the implementation of which is incorporated in the 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.

H. Token-Economy: The systematic arrangement within a person's environment whereby the person receives tokens contingent upon the occurrence of specified appropriate behaviors, without response cost contingencies. The tokens serve as a generalized conditioned reinforcer for appropriate behaviors and may be exchanged for a variety of privileges.

I. Other Techniques: These additional Level II Procedures also require BTRC review and approval when included as part of a formal Behavioral Treatment Plan:
   1. Removal of Inedible Item from Hand/Mouth Area (pica behaviors)
   2. Contingent Apology
   3. Planned Ignore Strategy/Selective Inattention
   4. Non-Exclusionary Time-Out Procedure
   5. Meal Interruption of 60 Seconds or More
   6. Stimulus Change
   7. Loss of Privileges
   8. Clean Up with Minimal Fuss and Attention

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9. Request to Turn over Stolen Items

Additional Behevior Modification Procedures Requiring Behavior Treatment Review Committee Approval:

A. Alarms installed for the treatment of a particular individual

B. Intensive Supervision: Arms length, direct line of sight supervision and one on one supervision and two on one supervision.

C. Removal of Personal Property where the property could be deemed to be harmful to self or others.

D. Restricting Access to or use of Personal Property: Limiting free access to an individual's personal property. Examples: clothing, cigarettes, lighters, items that can be of harm to self or others.

E. Search and Seizure: A procedure that involves searching a person or a person's belongings for a particular item. This procedure is part of a Behavior Treatment Plan designed to: increase adaptive, appropriate behavior, to decrease maladaptive behavior, and/or to promote safety. All searches must comply with the MMHC.

F. Medications Prescribed for Behavioral Control: The use of psychotropic medication for the purpose of decreasing a specific inappropriate behavior or sequence of behaviors. This procedure does not include the use of psychotropic medication to treat a mental illness and for the reduction of psychiatric symptoms such as, anxiety, depression, delusions and hallucinations or inappropriate affect.

Use of Medications for Behavior Treatment

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Medication is not used as: a punishment, for the convenience of staff, as a substitute for programming, or in quantities that interfere with an individual's developmental program. Whenever behavior modifying medications are utilized by a BABHA employed or contracted prescribing professional to eliminate maladaptive or problem behaviors, the individual's record documents the fact that less restrictive procedures of modifying or replacing the behavior(s) have been demonstrated to be ineffective. The need for a referral for behavior modifying medications is a decision of the individual person's person centered support team. A behavior modifying medication that offers the most effective treatment for the maladaptive or problem behavior(s) exhibited by the person shall be selected. When possible, only one behavior modifying medication should be prescribed for a person at any given time for behavior control. When two or more behavior modifying medications are prescribed for behavior control, the prescribing professional shall document in the progress notes the justification as well as the rationale for the concomitant use of two or more medications.

Medications used for behavior modification are utilized by the CMHSP employed or contracted prescribing professionals only as an integral part of an individual's plan. It is designed by the person centered support team to lead to a less restrictive way of treatment, and ultimately to the reduction and/or elimination of behaviors and/or reduction and/or elimination of medications being utilized.

A. Dosing

1. Dosage levels shall not ordinarily exceed those specified in one of the following: manufacturer's recommendations (package insert), Physician's Desk Reference (PDR), American Society of Health-System Pharmacists (ASHP) Formulary Service, AMA Drug Evaluation or GenRX.

2. If dosage levels are in excess of the maximum, the medical rationale shall be documented in the person's clinical record.

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3. The medication regimen must be individually determined by considering the person's need, age, sex, weight, physical condition, current illnesses, other medications and any previous adverse reaction to medication.

4. The person, parent of a minor child, or empowered guardian shall be advised of the medication's known side effects orally and in writing, and shall be instructed to report the occurrence of possible side effects to the prescribing professional or nurse.

5. The person shall be checked and routinely monitored for the presence of any condition affecting therapy.

6. The effects of the medication on the person's behavior and on the target symptoms shall be recorded in the clinical record. When the person's behavior or target symptom has stabilized and there is a need for long-term maintenance medication, the prescribing professional shall document the need in a progress note.

7. If a person's medication is changed, a progress note shall be written by the prescribing professional to document the rationale for the change.

B. Anticholinergic Agents

1. BABHA discourages the long term use of anticholinergic agents when used concomitantly with anti-psychotic agents. The rationale for concomitant use shall be documented in the person's clinical record.

2. In instances where a person experiences an extra-pyramidal reaction, an anticholinergic agent may be used. The person shall be gradually weaned from the anticholinergic agent until it is discontinued. The anticholinergic agent shall not be reinstated unless the person again exhibits an extra-pyramidal symptom. The

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prescribing professional shall document in a progress note the justification for use of an anticholinergic agent.

C. Tardive Dyskinesia

1. Each facility will utilize a standardized assessment scale to assess each person's prescribed medications that have the potential to produce or to contribute to Tardive Dyskinesia. This assessment scale shall be utilized at the time the psychotropic medication is initiated and at least quarterly thereafter, for the duration of the psychotropic medication's prescription.

2. A prescribing professional or a registered nurse shall complete the assessment scale and shall document the findings in the clinical record.

3. Each time a prescribing professional prescribes an anti-psychotic agent for a person for longer than three months, the prescribing professional shall weigh the benefits of continued use of the anti-psychotic agent against the risks of its long-term use, and shall document in a progress note, the basis of the decision, either to continue or discontinue the anti-psychotic medication.

The person's record contains written informed consent for the use of behavior modifying medications, signed by the person, if competent, or by the person's parent/guardian. This consent should be obtained by the prescribing professional.

Psychotropic medications for behavior modification may be prescribed by an employed or contracted prescribing professional on an emergency basis. This action should be documented on the prescribing professional review form and filed. A copy should be forwarded to the BTRC and a review scheduled.

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A psychiatric evaluation shall occur initially and every three years in all cases where a BABHA employed or contracted prescribing professional is prescribing psychotropic medications. If an individual is being treated by a prescriber not affiliated with BABHA,and the prescriber has prescribed psychotropic medications for behavior control the person's primary worker will request that the person or parent/guardian review the need for medication with the prescribing professional. The primary worker will advocate for the person and prescribing professional to participate in a behavior modification plan. If the person or his/her parent/guardian refuses to participate in such a plan, this refusal will be noted in the clinical record and review by the BTRC will not be required. However, the primary worker will continue to encourage the person's cooperation in developing a Behavior Treatment Plan.

Informed consent will be obtained at least annually from the person/parent/legal guardian. If classes of medications are changed, informed consent will again be obtained by the prescribing professional who will also review possible side effects with the person/parent/guardian.

Individuals of legal age, who are mentally competent to understand the purpose and nature of a Behavior Treatment Plan, participate in developing the plan for the use of behavior modifying medications, give permission for such use, and are allowed to discontinue such use if he/she so desires.

The parents of minors and/or legal guardians of adult persons receiving services, for whom the use of behavior modifying medications is proposed, are informed of the medications proposed for use. This information:

1. Conveys in a simple, non-technical, and comprehensive manner, the medications to be used, possible benefits, the specific behavior(s) for which the drug is being administered, and possible contraindications, hazards, side effects and interactions.

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2. Is given in such a form as is necessary to effectively communicate the information to the person and/or his/her legally competent representative. Notice to persons having perceptual or language impediments is given by a method or in a language that they can understand.

Persons receiving services, their parents and/or their guardians, have the right to refuse the proposed plan for the use of behavior modifying medications. In that event, BABHA has the right to appeal the matter to a court of appropriate jurisdiction for adjudication.

Prohibited Treatment Procedures

A. Any procedure that denies such basic needs as a nutritional diet, drinking water, shelter, or essential, safe, and appropriate clothing.

B. Aversive procedure: Any procedure that physically hurts an individual or has a likelihood of placing an individual at risk of psychological harm.

C. Corporal punishment: Punishment inflicted on a person's body.

D. Experimental medication: A medication that has not received the approval of the Food and Drug Administration (FDA) of the United States.

E. Fear-eliciting procedure: A procedure that is likely to result in an individual becoming afraid.

F. Mechanical restraint: A restraint device, such as a restraint chair or arm splints, used contingently upon the occurrence of a specific inappropriate behavior.

G. Psychosurgery: Brain surgery used to treat severe, intractable mental or behavioral disorders.

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H. Seclusion: The involuntary confinement of an individual**,** alone in a room, where the individual is physically prevented from leaving the room for any period of time.

I. Any behavior modification and treatment intervention that is implemented by another person receiving services. Persons receiving services are not allowed to implement another person's behavior plan, but positive interaction with peers, that may inadvertently be construed as positive reinforcement, is considered appropriate.

Monitoring by the Psychologist

The psychologist will conduct professional monitoring of plans with restrictive and/or intrusive interventions at least quarterly and more often based on the needs of the individual. The assigned psychologist will complete and document the periodic reviews. The BTRC will decide the frequency of monitoring by the BTRC when the plan is presented for review. The BTRC will review Plans requiring special consent least quarterly. The review will include review of progress, frequency of intrusive and/or restrictive interventions used, use of physical management, frequency of behavior, and calls to 9-1-1.

Attachments

N/A

Related Forms

Referral Form for Psychological Services (MCF)
BTRC Checklist (MCF)

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Related Materials

N/A

References and/or Legal Authority

1. Chapter III of the Michigan Medicaid Manual
2. Federal Balanced Budget Act
3. MDHHS Service Standards and Requirements
4. MDHHS Technical Requirement for Behavior Treatment Plan Review Committees FY12 Revision
5. Michigan Mental Health Code

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SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL /REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
Dave Breyer	CLT	3/10/2008	Revision	Revisions due to terminology/procedures changes to comply with MDCH guidelines
Dave Breyer	CLT	10/25/2010	Revision	Revisions are to comply with MDCH technical requirements as reflected in attachment 1.4.1 of the 2010 contract.
Ellen Albrecht	PNLT	10/3/2013	Revision	Triennial review: Updated with Person First Language. Changed date of DCH Technical Advisory to 2012
Ellen Albrecht	Ellen Albrecht/BTRC	5/28/15	Revision	Policy Statement reviewed for CARF. Changed MDCH to MDHHS. Moved from section 8 of the manual (4-8-1) to section 26 (4-26-1).
Ellen Albrecht	Christopher Pinter/BTRC	3/10/2017	Revision	Added types of plans; Added additional language related to frequency of monitoring by the psychologist; frequency of monitoring by the BTRC.
Karen Amon	BTRC	5/24/17	Revision	Eliminated terminology of Levels of plans. Included guidelines for 911 calls, made other changes to reflect contract guidelines.

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