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PROCEDURE

Application

This procedure shall apply to The Right Door for Hope, Recovery and Wellness and all services operated by or under contract with it, including children's foster. This procedure shall serve as a guide to assure compliance with Board policy regarding rights of persons served.

1.0 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 substance to consequent 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.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the person served for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the person served 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

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condition of the person served. Use of intrusive techniques as defined here requires the review and approval by the BTC.

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 as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent the individual from physically harming self 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, and lesser restrictive interventions have not reduced or eliminated the risk of harm. 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. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it IS NOT physical management if the individual stops the behavior without resistance.

- When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical

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management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

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**. 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 seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm 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. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

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

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precise strategy can be applied to all situations. Some examples of proactive strategies include: unconditional valuing, precursor behaviors, redirection, stimulus control and validating feelings. See the [prevention guide] for a full list of proactive strategies and definitions.

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. See the [prevention guide] for a full list of reactive strategies and definitions.

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 hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: The use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devises 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 recipient from causing serious self-injury associated with

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document and frequent incidents of the behavior and which are incorporated in the written individual plan of services 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.

- Medical restraint, i.e., the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles are considered safety devices and are not restraints as defined herein.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the rights of the person served as specified in the Mental Health Code and 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; to achieve therapeutic objectives; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); use of 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 BTC.

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 person served, 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 person served, guardian, or parent of a minor person served may only occur when the person served has been adjudicated pursuant to the provision of section 469a, 472a, 517,518, or 519 of the Mental Health Code.

2.0 Procedure

2.1 The Right Door for Hope, Recovery and Wellness shall have a Behavior Treatment Committee (BTC) to review and approve or disapprove any plan that proposes 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 Right Door for Hope, Recovery and Wellness and does not have its own BTC must also have access to and use the services of The Right Door for Hope, Recovery and Wellness BTC regarding a behavior treatment plan for an individual receiving services from The Right Door for Hope, Recovery and Wellness. If The Right Door for Hope, Recovery and Wellness delegates the functions of the BTC to a contracted mental health service provider, The Right Door for Hope, Recovery and Wellness must monitor that BTC to assure compliance.

2.2 The BTC shall be comprised of at least three individuals, one of whom shall be la licensed psychologist as defined in the Staff Provider Qualifications section of the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training; , and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights officer shall

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participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

2.3 The BTC and BTC chair shall be appointed by the agency for a term of not more than 2 years, members may be appointed to consecutive terms.

2.4 The BTC shall meet as often as needed.

2.5 Expedited Review of Proposed Behavior Treatment Plans shall occur as needed.

"Expedited" means the plan is reviewed and approved within a short time frame (24-48 hours).

2.5.1 Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation.

2.5.2 The Committee Chairperson may receive, review and approve such plans on behalf of the Committee.

2.5.3 The Office of Recipient Rights must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan.

2.5.4 Upon authorization, (which includes Person served/Guardian/Parent signature) the plan may be implemented.

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2.5.5 All plans approved in this manner must receive full review at the next regular meeting of the Committee.

2.6 The BTC shall keep minutes that clearly delineate the actions of the committee.

2.7 A BTC member who has prepared a Behavior Treatment Plan (BTP) for review shall recuse him/herself from the final decision-making on that plan.

2.8 The BTC shall disapprove any BTPs that propose to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

2.9 The BTC shall expeditiously review, in light of current peer reviewed literature or practice guidelines, all BTPs proposing to utilize intrusive or restrictive techniques (see definitions).

2.10 The BTC shall 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, disapproved any proposed plan of utilizing intrusive or restrictive techniques.

2.11 For each approved BTP, the BTC shall set and document a date to re-examine the continuing need for the approved procedures. This review shall occur as needed and determined by the BTC, 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. Plan with intrusive or restrictive techniques require minimally a quarterly review. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire BTP should be reviewed by BTC.

2.12 The BTC shall 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.

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2.13 The BTC shall arrange for an evaluation of the BTC's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

2.14 Once a decision to approve a behavior treatment plan has been made by the BTC and written special consent to the plan (see limitations in definition of special consent) 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 plan of service. 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 plan of service, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 3301712[2]).

2.15 The BTC shall on a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies. Should physical management or use of law enforcement be used more than 3 times in a 30-day period the plan is revisited and modified accordingly if needed. Tracking and analysis shall occur of the use of intrusive and restrictive techniques for each individual receiving the intervention, as well as:

2.15.1 Dates and numbers of interventions used.

2.15.2 The setting (e.g., group home, day program) where behaviors and interventions occurred.

2.15.3 Observations about any events, settings, or factors that may have triggered the behavior.

2.15.4 Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.

2.15.5 Description of attempts to use positive behavioral supports.

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2.15.6 Behaviors that resulted in termination of the interventions.

2.15.7 Length of time of each intervention.

2.15.8 Staff development and training and supervisory guidance to reduce the use of these interventions.

2.15.9 Review and modification or development, if needed, of the individual's behavior plan.

2.16 The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDHHS review. Any injury or death that occurs from the use of any behavior intervention is considered a critical incident that must be reported to MDHHS on a quarterly basis.

2.16.1 The BTC may advise and recommend to the agency the need for specific staff training or home-specific training in a culture of gentleness, positive behavioral supports, and other individual-specific non-violent interventions.

2.16.2 The BTC may 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 of harm. In addition, the BTC might recommend a limit for the number of emergency interventions that can be used with an individual in a defined period before the mandatory initiation of a process that includes assessments and evaluations, and possible development of a BTP.

2.16.3 The BTC may, at its discretion, review other formally developed BTPs, including positive behavioral supports and interventions, if such

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reviews are consistent with the agency's needs and approved in advance by the agency.

2.16.4 The BTC may advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.

2.16.5 The BTC may provide specific case consultation as requested by professional staff of the agency.

2.16.6 The BTC may assist in assuring that other related standards are met, e.g., positive behavioral supports.

2.16.7 The BTC may serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

2.17 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 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.

2.18 BTP's must be developed through the person-centered planning process and written special consent must be given by the individual, guardian, or the parent with legal custody of a minor prior to the implementation of the BTP that includes intrusive or restrictive interventions.

2.19 BTP's 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 BTC.

2.20 BTPs that propose to use restrictive or intrusive techniques as defined shall be reviewed and approved (or disapproved) the BTC.

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3.0 Behavioral Interventions

3.1 When assessing the causal factors related to an individual's behaviors, staff are to consider the precursors that may lead to specific behaviors, including but not limited to, medical conditions or symptoms, relationships and interactions the individual has with others in their environment, personal history/potential history of trauma, communication barriers and environmental condition

3.2 When engaging an individual exhibiting challenging behavior, staff are to create a safe, healing environment for all, emphasizing interventions that focus on prevention and holistic practices; ultimately, encouraging hope in the individual and their situation and promoting self-regulation.

3.3 When emergency physical interventions are utilized, they will be implemented for the shortest duration necessary, but under no circumstances will a physical intervention be implemented for longer than 15 minutes without attempting a release.

4.0 Presentations to BTC

4.1 Presentations to BTC will be the responsibility of the primary case coordinator or designee.

4.2 Presentations of new and annual reviews of behavioral treatment plans shall include:

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

4.2.2 A functional behavior assessment

4.2.3 Results of inquiries about any medical, psychological or other factors

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that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.

4.2.4 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.

4.2.5 Evidence of continued efforts to find other options.

4.2.6 Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.

4.2.7 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.

4.2.8 The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

5.0 Each Behavior Treatment Plan has:

5.1 Goal- expected outcome of the Behavior Treatment Plan

5.2 Objectives –baseline and steps to achieving the behavior goal

5.3 Methodology-interventions implemented to decrease target behaviors, a schedule and /or timing and things to be done to increase additional adaptive behaviors

5.4 How the baseline will be established, what is being measured, and assessment of the impact of behavior treatment interventions on the individual.

5.5. Plan Review- frequency of reviewing collected data

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5.6 Staff In-Service –who is responsible for training staff and when the plan will be implemented. Evidence of staff training/in-servicing of plan.

5.7 Staff Responsible- the CM who will implement and manage the plan.

Kerry Possehn, Chief Executive Officer	Date		