CHAPTER: Organizational Management
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SECTION: Quality Management
SUBJECT: Behavior Management Review Committee

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I. APPLICATION
☐ PIHP Board ☑ CMH Personnel ☐ Genesee County CA ☐ Other:
☑ PIHP Personnel ☑ CMH Sub-Contractors ☐ CA Sub-Contractors

II. SCOPE
The PIHP Behavior Management Review Committee (BMRC) shall provide required review and approval/disapproval for all treatment plans proposing use of restrictive or intrusive interventions, for all PIHP Network providers. Any 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 PIHP that does not have its own equivalent review committee, shall have access to the PIHP BMRC. Delegation of BMRC functions to a Network Provider is at the discretion of the PIHP and requires PIHP monitoring to assure that the delegated committee complies with this policy, and with Michigan Department of Community Health policy and contract requirements.

III. POLICY STATEMENT
Any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. The PIHP has in place policies and procedures for intervening, using the least intrusive and restrictive interventions, with individuals receiving public mental health services who, on an emergency, unprecedented or unpredicted basis, exhibit seriously aggressive, self-injurious or other behavior that place the individual or others at risk of harm.

When serious aggressive, self-injurious, or other behavior that places an individual or others at risk of harm occurs on a non-emergent, continuing basis, appropriate assessments will be completed to rule out any physical, medical, and environmental factors related to these behaviors. Through the person-centered planning process and based on results of these assessments, formal behavior treatment plans may be developed to treat, manage, control, or extinguish these behaviors. These behavior treatment plans will be developed with the purpose of ameliorating or eliminating the need for restrictive or intrusive interventions in the future. Behavior plans will ensure:
- adherence to psychiatric advance directives for adult SMI individuals
- use of positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches
- consideration of other kinds of behavioral supports and interventions, supported by peer-review or practice guidelines, if positive supports are documented to be unsuccessful
as a last resort, when there is documentation of failure of positive interventions or other kinds of interventions, the behavior plan may propose restrictive or intrusive techniques and shall be approved by the Behavior Management Review Committee prior to implementation.

Per Michigan Department of Community Health policy, a specially constituted committee, referred to here as the Behavior Management Review Committee (BMRC), shall review and approve or disapprove any plan of service proposing the use of restrictive or intrusive interventions for individuals who exhibit seriously aggressive, self-injurious or other behavior that place the individual or others at risk of harm. Behavior Management Committee review is required for all behavior or other treatment plans that propose the use of:

- restrictive techniques,
- intrusive techniques, or
- use of psychotropic medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process

It is the responsibility of the clinical program staff (usually the behavior program author) to assure that BMRC review is requested consistent with this policy and that restrictive or intrusive interventions included in behavioral treatment plans are not implemented without prior BMRC approval. In addition, staff implementing the individual’s behavior management plan must be trained in how to implement the plan.

IV. STANDARDS

A. BMRC Appointment:
   1. The BMRC shall be comprised of at least three individuals, one of whom shall be a fully or limited licensed psychologist with training and experience in applied behavior analysis; and at least one member shall be a licensed physician/psychiatrist. At least one of the committee members shall not be the developer or implementer of the behavior management plan. The psychologist or physician must be present during the review and approval process. A representative of the Office of Recipient Rights shall participate on the BMRC as an ex-officio, non-voting member in order to provide consultation and technical assistance to the BMRC. 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.
   2. The Committee and Committee chair shall be appointed by the agency for a term of not more than two years and members may be re-appointed to consecutive terms.
   3. The Committee shall meet as often as needed.
   4. The Committee shall keep all its meeting minutes and clearly delineate the actions of the Committee.
   5. The Committee shall ask that a Committee member who has prepared a behavior treatment plan to be reviewed by the Committee excuse themselves from the final decision-making.

B. BMRC Functions:
   1. Disapprove any behavior treatment plan that proposes the use of aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
   2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
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. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. Review shall occur no less than monthly from the date of 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 behavior treatment plan should be reviewed by the Committee.

5. Assure that inquiry has been made about any medical, psychological or other factors that the individual has which might put him/her at risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

6. Arrange for an evaluation of the Committee’s effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. Once a decision on a behavior treatment plan has been made by the BMRC and written special consent to the plan has been obtained, it becomes part of the person’s written IPOS. The individual, legal guardian, parent with legal custody or a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan.

7. Annually track the use of all physical management for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention as well as:
   i. Date and numbers of interventions used
   ii. Behaviors that initiated the techniques
   iii. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention
   iv. Attempts to use positive behavioral supports
   v. Behaviors that resulted in termination of the interventions
   vi. Length of time of each intervention

8. The collected data on the use of intrusive and restrictive techniques must be evaluated by the PIHP’s Quality Assessment and Performance Improvement Program and be available for MDCH review. Physical management is permitted for intervention in emergencies only.

9. In addition, the BMRC may:
   i. Advise and recommend to the agency the need for specific staff training in positive behavioral supports and other interventions
   ii. Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk or harm. In addition, the Committee 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 behavior treatment plan, as described and required.

iii. At its discretion, review other formally developed behavior treatment plans, including positive supports and interventions, if such reviews are consistent with the agency’s needs and approved in advance by the agency.

iv. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.

v. Provide specific case consultation as requested by professional staff of the agency.

vi. Assist in assuring that other related standards are met (e.g. positive behavioral support).

vii. Serve another service entity (e.g. subcontractor) if agreeable between the involved parties.

C. Behavior Treatment Plan Standards:

1. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that 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, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan.

3. Behavior treatment plans that propose to use physical management in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the Committee.

4. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.

5. Plans that are forwarded to the Committee 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 continued efforts to find other options.

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

   vi. 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.

   vii. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).
D. Definitions:

*Applied Behavior Analysis* - The organized field of study, which has its objective the acquisition of knowledge about behavior using accepted principles of behavior based on 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 subspecialty 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 (or stimuli that 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. Use of aversive techniques is prohibited.

*Intrusive Techniques* - Those techniques that make physical contact with or invade the recipient’s body, or encroach upon his/her personal space for the purpose of achieving management control, or extinction 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 forcing an individual to ingest a medication or receive an injection of a drug that is used to control or extinguish the behavior and is not otherwise used as a standard medication for the individual’s condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

*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.

*Physical Management* - A technique used by a 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.
**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.

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

**Restraint** - Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of the recipient to move his or her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others as risk of physical harm. 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. The definition also excludes safety devices required by law, such as car seat belts or child car seats while riding in a vehicle. The use of physical or mechanical devices used as restraints is prohibited except in a state-operated facility or a licensed hospital.

**Restrictive Techniques** - Those techniques which, when implemented will result in the limitation of the individual’s rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the 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, use of the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Restrictive techniques include the use of a drug or medication when it is used as a restriction to manage, control, or extinguish an individual’s behavior or restrict freedom of movement and is not a standard treatment or dosage for the individual’s condition. Use of restrictive techniques requires the review and approval of the Committee.

**Seclusion** - The placement of an individual in a room alone where egress is prevented by any means. Seclusion is prohibited except in a hospital or center operated by MDCH, a hospital licensed by the department, or a licensed child caring institution.

**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 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 service 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 may occur only when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
E. References:
- 1997 federal Balanced Budget Act at 42 CFR 438.100
- Medicaid Provider Manual
- Department of Community Health Administrative Rule 330.7199(2)(g)
- MDCH Contract Attachment 1.4.1 (Technical Requirement for Behavior Treatment Plan Review Committees)

V. DEVELOPMENT AND REVIEW:
This policy shall be reviewed at least annually by the Director of Quality and Utilization Management.

IV. IMPLEMENTATION AND REVISIONS:
02-02-99 - implemented
03-16-01 - revised
12-01-01 - revised
02-25-02 – revised
09-08-03 – revised
11-05-03 – revised
06-14-04 – revised
11-01-04 – revised
08-01-05 – revised
10-01-08 – revised
12-04-09 – revised