



HURON BEHAVIORAL HEALTH
OPERATIONAL POLICY

Policy #: **BM.1.01**

Issue Date: 1985

Rev. Date: 01/31/17

Page: 1 of 14

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

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Purpose:

To define Huron Behavioral Health's (HBH) philosophy regarding Behavior Treatment Plans in a manner which meets the requirements set forth in the Mid-State Health Network (MSHN) policy "Behavior Treatment Plans", the Michigan Department of Health and Human Services (MDHHS) contractual Technical Requirements, and the Council on Accreditation (COA) standards.

Scope:

This policy applies to all HBH Programs and all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH) who are involved in writing, monitoring or reviewing behavior treatment plans. It also applies to all consumers served by HBH who have behavior treatment plans. This policy applies to all populations and all programs including children, adults, residential, community based services, etc. When the consumer is a minor, the parent or legal guardian is notified and involved regarding any needed behavior treatment plans.

Information:

1. It is the philosophy of Huron Behavioral Health to provide a culture of gentleness and to provide a safe and therapeutic environment and to provide the necessary supports and resources to the consumers we serve. This environment promotes keeping staff and consumers safe and minimizes the use of restrictive and/or intrusive behavior management interventions. It is the philosophy of HBH that when consumers feel safe and secure, they are less likely to act out with behaviors that require the use of physical interventions. In all cases, the rights and privileges of the consumer shall be safeguarded, including the right to safe and effective treatment. Positive Reinforcement Procedures or strategies are utilized, as positive reinforcement tends to be most successful when programs are developed around the consumers' needs and demonstrated abilities.
2. 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 a guardian has been appointed, or the parent with legal custody of a minor. Functional behavioral assessments must be conducted to rule out physical, medical, or environmental causes of the behavior in order to initiate restrictive or intrusive techniques, the behavior treatment plan must be accompanied by evidence of the kinds of positive behavioral supports or interventions that have been attempted but proven unsuccessful in reducing/eliminating the behaviors.
3. HBH staff shall not utilize any of the prohibited behavior treatment procedures defined in section "A" below.
4. It is the philosophy of Huron Behavioral Health to build positive relationships with the consumers it serves. This includes building upon the consumer's strengths and reinforcing positive behaviors. HBH staff is prohibited from using any form of harassment and/or violence and are subject to strict and prompt disciplinary measures in accordance with the "[HBH Employee Handbook](#)" (PPM.00).
5. HBH believes that all consumers served have the right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation as required by the 1997 federal Balanced Budget Act (42 CFR 438.100, and the Michigan Mental Health Code sections 740 & 742).
6. The use of restrictive procedures/techniques shall be done in conjunction with a total program effort, which should emphasize positive behavioral support as a preventative strategy. Non-physical techniques are the only HBH-sanctioned interventions for modifying behavior. 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 or intrusive techniques may be a reasonable therapeutic approach. Under such conditions, these techniques may not only be necessary, but may represent the only viable way to make available the

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 2 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

person's right to habilitation. Consistent with this rationale, HBH supports the controlled use of such interventions. Any restriction or limitation shall be justified, time-limited, and clearly documented in the Behavior Treatment Plan.

7. Restrictive procedures may only be 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. These may only be used after considering less restrictive alternatives.
8. Only two (2) forms of emergency intervention may be utilized in a crisis situation. This includes the use of physical management and the request for law enforcement intervention. Emergency physical management may only be used when there is imminent risk (i.e. an event/action that is about to occur is likely to result in potential harm to self or others). Any use of physical interventions must be documented on an "Incident Report Form" (DCH-0044) and an "[Emergency Physical Intervention Report Form](#)" (90-452) (see also "[Unusual Incident Reporting Procedure](#)" RR.2.37).
9. Recipient Rights standards are to be adhered to in order to support and enforce this policy. Recipients have the right to a habilitation program designed to help them to progress to a less restrictive and less aversive setting. HBH will not tolerate violence perpetrated on its consumers in the name of intervening when individuals exhibit certain potentially harmful behaviors. If any interventions are used for the purpose of treating, managing, controlling, or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the consumer or others at risk of harm, HBH will develop an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R.330.7199[2][g]), and that:
 - Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
 - Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
 - Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or
 - As a last resort when there is documentation that neither positive behavior supports and/or interventions were successful, proposed restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee (BTPRC). (See also "[Behavior Treatment Plan Review Committee \(BTPRC\) Procedure](#)" (BM.2.01).

Policy:

A. PROHIBITED TREATMENT TECHNIQUES:

1. **The following treatment procedures are strictly prohibited from use under any circumstance:**
 - a. Any procedure that denies such basic needs as 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. More specifically, any technique that requires the deliberate infliction of unpleasant stimulation (i.e. stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person).
 - c. **Contingent Harmless Substances** – i.e. taking a spray bottle spraying water at the individual
 - d. **Corporal Punishment** – Punishment inflicted on a person's body.
 - e. **Discipline of Consumers** - Discipline is a means of punishment in order to correct or train a person. Staff is not permitted to use discipline of consumers in lieu of an approved behavior modification intervention. Consumers are not permitted to discipline other consumers.
 - f. **Experimental Medication** - A medication that has not received the approval of the Food and Drug Administration (FDA) of the United States.
 - g. **Fear-Eliciting Procedure** - A procedure that is likely to result in an individual becoming afraid.

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 3 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

- h. **Forced Physical Exercise to Eliminate Behaviors** – i.e. making the individual run or do push-ups as punishment
- i. **Group Punishment** – Disciplining a group of individuals for an individual's behavior
- j. **Isolation** – The practice of separating a person from others and placing him/her in a monitored, non-locked or "quiet" room in order to calm the person. A person in isolation is physically prevented from leaving the designated space or room where s/he is placed. For purposes of COA accreditation, isolation is distinguished from TIME-OUT.
- k. **Mechanical Restraint** - A restraint device, such as a restraint chair or arm splints, used contingently upon the occurrence of a specific inappropriate behavior. Restraint does not include the use of a device primarily intended to provide anatomical support.
- l. **Physical Management Involving Prone Immobilization** - 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/her from moving out of the prone position. This behavior is prohibited under any circumstances.
- m. **Punishment by Peers** - Any behavior modification and treatment intervention that is implemented by another consumer. Consumers are not allowed to implement another consumer's behavior plan, but positive interaction with peers, that may inadvertently be construed as positive reinforcement, is considered appropriate.
- n. **Psychosurgery** - Brain surgery used to treat severe, intractable mental or behavioral disorders.
- o. **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.

B. Requirements for Behavior Treatment Plans:

- 1. Behavior Treatment Plans shall be written, implemented, and monitored in compliance with HBH policies, as well as MSHN policy and MDHHS Technical requirement, and federal guidelines and standards defined in this policy using the "[HBH Behavior Treatment Plan Form](#)" (90-451). HBH staff shall utilize the least restrictive/intrusive methodology and behavior modification techniques as possible using a hierarchy of least restrictive techniques. In all cases, the rights and privileges of the consumer shall be safeguarded, including the right to safe and effective treatment. A formal written Behavior Treatment Plan is necessary for restrictive and/or intrusive procedures. Restrictive and/or intrusive procedures are defined in section "F" of this policy. A formal written Behavior Treatment Plan is necessary when medications are given for behavior control and/or for the purpose of behavior management.
- 2. Each behavior treatment plan shall specify the target behavior, treatment objectives, proposed interventions, data , and/or tracking strategy, plan review, responsible staff, and supervising clinician

C. Behavior Treatment Plans Requiring Special Consent:

- 1. Any Behavior Treatment Plan that proposes the use of restrictive or intrusive interventions set forth within this policy requires special written consent. Consent must be provided by the individual, the legal guardian, the parent with legal custody of a minor child, or designated patient advocate prior to implementation.

D. Emergency Physical Intervention Procedures:

- 1. Emergency physical intervention (EPI) techniques may only be used as a last resort to protect a person who exhibits behavior that is dangerous to self or others, or who engages in serious property destruction. In all cases, a hierarchy of least restrictive techniques will be followed (see also "[Emergency Physical Interventions / Non Violent Crisis Interventions \(NVCI\) Policy](#)" BM.1.03). These procedures may never be employed as punishment, for the convenience of staff, or as a substitute for programming.
- 2. The staff utilizing an emergency physical intervention technique must document its use on an "Unusual Incident Report Form" (DCH-0044), and provide evidence that there was no alternative for preventing physical injury to a recipient, to others, or for preventing the imminent destruction of property. The completed incident report form must be submitted to the HBH Recipient Rights Officer. See also "[Unusual Incident Reporting Procedure](#)" RR.2.37).

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 4 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

3. The use of an emergency physical intervention technique would typically not exceed fifteen (15) minute duration followed by a release to allow the person to regain self-control and must immediately be stopped if any signs of physical distress occur. In all cases, the rights and privileges of the consumer shall be safeguarded, including the right to safe and effective treatment. If the intervention is to be continued, the Home Manager or Supervisor must be contacted.
4. Each use of an emergency physical intervention shall be reported within one (1) business day using the "[Emergency Physical Intervention Report Form](#)" (90-452) and forwarded to the HBH Recipient Rights Officer.
5. Staff authorized to use therapeutic intervention techniques are those certified through explicit training in approved physical intervention techniques and by determination of the program supervisor.
6. If the same consumer is repeatedly requiring the use of emergency physical intervention, the treatment team will meet to address the use of the emergency procedures, evaluate the Behavior Treatment Plan, or the need for such a plan, and request a review by the BTPRC.
7. When food is provided as part of a behavior treatment program, its effect on nutrition and dental status is considered. The primary worker is responsible to insure that foods which are deleterious to health are not used as rewards unless it is documented that alternative rewards have been tried without success. Behavior treatment programs cannot employ, nor result in, the denial of a nutritionally adequate diet.

F. Behavior Treatment Plan Standards:

1. The Person-Centered Planning (PCP) process is used in the development of an individualized written plan of service. (see also "[Person-Centered Plan \(PCP\) Policy QI.1.05](#)" and "[PCP Procedure](#)" QI.2.18) and will identify when a behavior treatment plan is needed. Assessments are conducted during this process to rule out physical, medical, or environmental causes of the behavior; and that unsuccessful attempts using positive behavioral supports and interventions have been made to change the behavior.
2. 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.
3. 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. Behavior treatment plans that include such interventions will be approved by the BTPRC.
4. Behavior treatment plans that propose the use of restrictive or intrusive techniques as defined by this policy must be reviewed and either approved or disapproved by the BTPRC.
5. Staffing ratios and training will be adequate for implementation of the behavior treatment plan.
6. Behavior treatment plans that are forwarded to the BTPRC shall be accompanied by:
 - a. Results of assessments performed to rule out relevant physical, medical, and environmental causes of the problem behavior
 - b. A functional assessment
 - c. Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury, or trauma
 - d. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope, duration that have been attempted to ameliorate the behavior and have proved unsuccessful
 - e. Evidence of continued efforts to find other options
 - f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention
 - g. Reference to literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available
 - h. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s)

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5. Behavior Treatment Plans shall be reviewed as necessary, but at a minimum at least quarterly by the Behavior Treatment Plan Review Committee (BTPRC). (See the "Behavior Treatment Plan Review Committee Procedure" BM.2.01).

G. Behavior Treatment Procedures:

1. Behavior treatment programs are to be directed toward maximizing the growth and development of the consumer by incorporating the hierarchy of available procedures that emphasize positive approaches. Positive reinforcement tends to be the most successful when programs are developed around individual consumer's needs and demonstrated abilities. The following strategies are preferred. **These procedures may be used by staff and do not require authorization by any administrator, consumer, guardian, or the HBH BTPRC:**

Behavior Modification Procedures	
These Procedures do not require a Behavior Treatment Plan or authorization by administrator, consumer, Guardian, or BTPRC:	
Behavior Chains	A sequence of stimuli and responses that end with terminal behavior, such as forward chaining, backward chaining, and total task chaining. <ul style="list-style-type: none"> • 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. • 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. • Total Task Chaining is a procedure where the behavioral sequence is broken into small steps and a person is trained in all steps simultaneously.
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. <p>Differential Reinforcement of Other Behavior(s) (DRO) - is a procedure where any behavior other than the target behavior is reinforced on a periodic schedule</p> <p>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</p> <p>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</p> <p>Differential Reinforcement of Low Rates of Behavior(s) (DRL) -is a procedure where the infrequent occurrence (rate) of a target behavior is reinforced</p> <p>Differential Reinforcement of High Rates of Behavior(s) (DRH) - is a procedure where the frequent occurrence (rate) of a target behavior is reinforced</p>
Extinction	Is 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.
Fading	The gradual change of stimulus control. Fading is used to foster independence by eliminating control that prompts have had over a person's behavior.
Instructional Control	The delivery of information about the incorrectness/inappropriateness of a person's behavior. Such instructions may be effected through manual guidance of the person. Such instructions may be effected through manual guidance of the person through the correct response, a prompt, or verbal statement such as "yes" or "no", "correct" or "wrong". Instructional control is not considered restrictive.
Interruption	Is the use of a verbal cue to break in upon an action, e.g. "Please, Stop! You may not spit on the floor."
Low Stimulation	Is a consumer'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.
Non-contingent Reinforcement	Is the delivery of a reinforcer that is not dependent upon the occurrence or non-occurrence of a target behavior.
Positive Practice	A procedure in which a person behaving inappropriately, is requested to and voluntarily complies with, repeated practice of 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.
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.
Prompting	An additional discriminative stimulus that is presented in order to cue the person to perform a specified

Title: Behavior Treatment Plan PolicyProcedure #: **BM.1.01**

Issue Date: 1985

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Rev. Date: 01/31/17

Page: 6 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

	behavior. Prompts may be verbal, gestural, or involve physical guidance. <ul style="list-style-type: none"> a. Verbal prompts are defined as oral sounds or sign language signs presented to a person to cue performance of a specific task b. Gestural prompts are defined as pointing, hand movements, or other body movements presented to a person to cue performance of a specific task c. Physical prompts are defined as non-restrictive physical contacts with a person, using no significant physical pressure, to cue performance of a specific task
Redirection	Is an initial verbal prompt, which may be paired with a physical prompt that guides the individual to the appropriate activity.
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.
Shaping	The process of differentially reinforcing successive approximations (small steps) toward the desired level of behavior until the behavioral sequence is fully achieved.
Stimulus Change	Is the altering of stimuli to create a situation so different from that which previously existed that the ongoing behavior is temporarily suppressed.
Other Voluntary Techniques	The following commonly accepted practices, while not an exhaustive list, are also included to illustrate additional procedures which do not require administrator, consumer, guardian, or other approving authority to use: <ul style="list-style-type: none"> ▪ Anger Management Techniques/Calming Strategies/Self-Control Activities & Exercises ▪ Social Skills Training ▪ Social Stories ▪ Picture Activity Schedules ▪ Structured Social/Activity Involvement ▪ Daily Positive Interaction Time (with parent or staff member) ▪ Daily/Weekly Outings or Other Rewards (beyond what is specified in the consumer's PCP) ▪ Problem Solving Discussions ▪ Structured Relaxation Training ▪ Suggested Relaxation ▪ Teach/Train Positive Activity with Property (for individuals who exhibit property damage) ▪ Nighttime Bed Checks for Enuresis/Encopresis (Toileting Schedule) ▪ Behavioral Contracting/Contingency Contracting ▪ Visual Demonstration of Personal Space (arm's length away) ▪ Compliance Training ▪ 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) ▪ Structured Alone Time ▪ Daily Journaling ▪ Encourage Incompatible Behavior As Targeted Behavior Occurs
Restoration/ Restitution/Simple Correction:	Is the requiring of a person to return an environment to a former or original state or return an item that has been removed.

2. Behavior Modification Procedures and Techniques - Intrusive and/or Restrictive:

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 represent the only viable way to make available the person's right to habilitation. In all cases, the hierarchy of least restrictive techniques will be followed. Restrictive procedures are to be used in conjunction with a total program effort, which should emphasize positively reinforcing program strategies.

Written informed consent by the consumer or the consumer's guardian is required for all restrictive/intrusive procedures. 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.

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: **BM.1.01**

Issue Date: 1985

Rev. Date: 01/31/17

Page: 7 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

The BTPRC shall review all restrictive and/or intrusive procedures and these procedures must be authorized by the BTPRC in writing before they may be implemented.

Behavior Modification - Intrusive and Restrictive Procedures

The BTPRC must review and authorize (in writing) these procedures before they may be used.

These require written legal consent by the consumer or the consumer's guardian. There must be a Behavior Treatment Plan developed through the PCP process and be approved by the individual, or his/her guardian (if one has been appointed), or the parent with legal custody of a minor.

Alarms	Alarms installed for treatment of a particular individual.
Intensive Supervision	Arms length, direct line of sight supervision and one-on-one supervision and two-on-one supervision.
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 for the reduction of psychiatric symptoms such as, anxiety, hallucinations, or inappropriate affect.
Negative Practice	A procedure in which a person, behaving inappropriately, is required to repeatedly practice the inappropriate behavior in order to reduce that behavior.
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.
Removal of Personal Property	The removal of personal property where property could be deemed to be harmful to self or others.
Response Cost	The response-contingent removal of a positive reinforcer. A previously earned reinforcer or access to personal property may be removed.
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.
Restricting Access to or Use of Personal Property	Limiting free access to an individual's personal property. Examples include: clothing, cigarettes, lighters, items that can be of harm to self or others.
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).
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 Michigan Mental Health Code.
Therapeutic De-Escalation	An intervention, the implementation of which is incorporated in the individual written plan of service, 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.
Token-Economy with a Response Cost	The systematic arrangement within a person's environment whereby the person receives tokens contingent upon the occurrence of specified appropriate behaviors, with response cost contingencies. The tokens serve as a generalized conditioned reinforcer for appropriate behaviors and may be exchanged for a variety of privileges. A token economy without a response cost is not considered a restrictive intervention.
Other Techniques –	These additional restrictive and/or intrusive procedures also require BTPRC review and approval when included as part of a formal Behavioral Treatment Plan: <ul style="list-style-type: none"> • Removal of Inedible Item from Hand/Mouth Area (pica behaviors) • Contingent Apology • Planned Ignore Strategy/Selective Inattention • Non-Exclusionary Required Relaxation • Non-Exclusionary Time-Out Procedure • Meal Interruption of sixty (60) Seconds or More • Stimulus Change • Loss of Privileges

Title: Behavior Treatment Plan Policy

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Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 8 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

- Request to Turn Over Stolen Items

3. Use of Medications for Behavior Treatment:

Medication shall not be used as:

- Punishment
- For the convenience of staff
- As a substitute for programming, or
- In quantities that interfere with an individual's developmental program.

A formal written Behavior Treatment Plan is necessary when medications are given for behavior control and/or for the purpose of behavior management. Whenever behavior-modifying medications are employed by HBH physicians to eliminate maladaptive or problem behaviors, the consumer's case record shall document the fact that less restrictive procedures of modifying or replacing the behaviors have been demonstrated to be ineffective. The need for a referral for behavior-modifying medications is a decision of the consumer's treatment and support team. A behavior-modifying medication which offers the most effective treatment for the maladaptive or problem behaviors exhibited by the consumer shall be selected. When possible, only one (1) behavior-modifying medication should be prescribed for a consumer at any given time for behavior control. When two (2) or more behavior-modifying medications are prescribed for behavior control, the prescribing physician shall document in the case record the justification as well as the rationale for the concomitant use of two (2) or more medications.

Medications used for behavior modification are utilized by HBH physicians only as an integral part of a consumer's plan. It is designed by the person centered treatment team to lead to a less restrictive way of treatment, and ultimately to the reduction and/or elimination of medications being utilized.

A Psychiatric Evaluation should occur in all cases where a psychiatrist is prescribing psychotropic medications to control behaviors.

a. Medication Dosing:

- 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.
- If dosage levels are in excess of the maximum, the medical rationale shall be documented in the consumer's case record.
- The medication regimen must be individually determined by considering the consumer's need, age, sex, weight, physical condition, current illnesses, other medications and any previous adverse reaction to medication.
- The consumer, 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 physician or nurse.
- The consumer will be checked and routinely monitored for the presence of any condition affecting therapy.
- The effects of the medication on the consumer's behavior and on the target symptoms shall be recorded in the case record. When the consumer's behavior or target symptom has stabilized and there is a need for long-term maintenance medication, the physician shall document the need in a progress note.
- If a consumer's medication is changed, a doctor's note shall be written by the prescribing physician to document the rationale for the change.

b. Anticholinergic Agents:

- HBH 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 consumer's case record.
- In instances where a consumer experiences an extra-pyramidal reaction, an anticholinergic agent may be used. The consumer shall be gradually weaned from the anticholinergic agent until it is discontinued. The

Title: Behavior Treatment Plan Policy

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Procedure #: **BM.1.01**

Issue Date: 1985

Rev. Date: 01/31/17

Page: 9 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

anticholinergic agent shall not be reinstated unless the consumer again exhibits an extra-pyramidal symptom. The physician shall document the justification for use of an anticholinergic agent in the consumer's case record.

c. Tardive Dyskinesia:

- A standardized assessment scale (AIMS - Abnormal Involuntary Movement Scale) is used to assess each consumer'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.
- A Physician or a Registered Nurse (RN) shall complete the assessment scale and shall document the findings in the consumer's case record.
- When a physician prescribes an anti-psychotic agent for a consumer for longer than three (3) months, the physician shall weigh the benefits of continued use of the anti-psychotic agent against the risks of its long-term use, and shall document in the consumer's case record, the basis of the decision, either to continue or discontinue the anti-psychotic medication.

d. Medication Consent:

- The consumer's case record must contain written legal consent for the use of behavior modifying medications, signed by the consumer, if competent, or by the consumer's parent/guardian. (See also Psychotropic Medications Procedure" (RR.2.15). This consent should be obtained by the prescribing physician.
- Psychotropic medications for behavior modification may be prescribed by the HBH physician on an emergency basis. This action should be documented in the consumer's case record. This is to be documented in the consumer's case record and a copy should be forwarded to the BTPRC to be reviewed. A psychiatric evaluation should occur in all cases where an HBH physician is prescribing psychotropic medications.
- If a consumer is receiving a psychotropic medication for behavior control from a physician who is not employed by HBH, the primary worker will request that the consumer or parent/guardian review the need for medication with the prescribing physician. The primary worker will advocate for the consumer and physician to participate in a behavior treatment plan. If the consumer 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 BTPRC will not be required. However, the primary worker will continue to encourage the consumer's cooperation in developing a Behavior Treatment Plan.
- On an annual basis, medication consent will be obtained from the consumer/parent/legal guardian (see also "Psychotropic Medications Procedure" RR.2.15). If classes of medications are changed, legal consent will again be obtained by the prescribing physician who will also review possible side effects with the consumer/parent/guardian.
- Individuals of legal age, who are mentally competent to understand the purpose and nature of a Behavior Treatment Plan, should participate in developing the plan for the use of behavior modifying medications, give their consent for such use, and are allowed to discontinue use if he/she so desires.
- The parents of minors and/or legal guardians of adult consumers, for whom the use of behavior modifying medications is proposed, are informed of the medications proposed for use. This information:
 - 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.
 - Is given in such a form as necessary to effectively communicate information to the consumer and/or his/her legally competent representative. Notice to consumers having perceptual or language impediments is to be given by a method or language that they can understand. (See also RR.1.01 "Limited English Proficiency (LEP) Policy".)

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 10 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

- Consumers, their parents and/or guardians, have the right to refuse the proposed plan for behavior modifying medications. If this occurs HBH has the right to appeal the matter to a court of appropriate jurisdiction for adjudication.

Definitions/Acronyms:

DEFINITIONS: (The following definitions are in accordance with MDHHS Services Standards)

- **Applied Behavior Analysis:** Means 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:** refers to those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have an 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 the 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 (eg. exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this policy. Otherwise, use of aversive techniques is prohibited. **It is the policy of HBH that that aversive interventions are prohibited by any direct or contract provider employee.**
- **Behavior Assessment/Functional Analysis:** refers to a document that contains a precise description of a consumer's behavior, its context, and its consequences, with the intent of better understanding the behavior and those factors influencing it. A behavior assessment/functional analysis (using the "Behavior Assessment Form" 90-475) must occur prior to the establishment of a Behavior Treatment Plan. The behavior assessment/functional analysis addresses the following issues associated with identified target behaviors: environmental and contextual factors (antecedent, behavior, and consequence) and the consumer'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 identified and the frequency, duration, and/or intensity of the target behavior(s) is assessed.
- **Behavior Management:** 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 HBH to employ behavior modification treatment techniques rather than behavior management techniques when the technique used is not needed to assure safety.
- **Behavior Modification:** refers to 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 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 Plan Review Committee (BTPRC):** 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 consumers.
- **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.

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: **BM.1.01**

Issue Date: 1985

Rev. Date: 01/31/17

Page: 11 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

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. In conjunction with affiliate data collection and reporting activities, HBH reviews and monitors the use of behavior treatment interventions to monitor and improve treatment efficacy.

- **Consent:** refers to a written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.
- **Functional Behavioral Assessment (FBA):** refers to an approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an affective and efficient behavior plan. The focus of a FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessment as should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan.
- **Emergency interventions:** There are only two (2) emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. HBH has defined the protocols that may be used in "[Emergency Physical Interventions / Non Violent Crisis Interventions \(NVC\) Policy](#)" **BM.1.03**.
- **Imminent Risk:** refers to an event/action that is about to occur that will likely result in the potential harm to self or others.
- **Intrusive Techniques:** refers to 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 BTPRC Committee.
- **Peer-Reviewed Literature:** refers to 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 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:** refers to 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 himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places an individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff, HBH has designated emergency physical management techniques to be utilized during emergency situations (see also "[Emergency Physical Interventions / Non Violent Crisis Interventions \(NVC\) Policy](#)"). Physical management, as defined here, shall not be included as a component of a behavior treatment plan. Also, 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. The following are examples to further clarify the definition of physical management:
 - Manually guiding down the hand/fist on an individual who is striking his/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/herself. However, it is NOT physical management if the individual stops the behavior without resistance.

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 12 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

- When a caregiver places a hand on an individual's biceps to prevent him/her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.
- Positive Behavior Support: refers to a set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills, and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction, and pica. 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: refers to the guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
- Proactive Strategies in a Culture of Gentleness: refers to 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: refers to strategies within a positive behavior support plan used to respond when individuals begin to feel 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.
- Request for Law Enforcement Intervention: Refers to calling 9-1-1 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: Refers to 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:
 - Anatomical or physical supports that are ordered by a physician, physical therapist, or occupational therapist for the purpose of maintaining or improving and individuals' 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 which are incorporated in the written individual plan of service through a behavior treatment plan which has been reviewed and approved by the BTPRC 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.
- Restrictive Techniques: refers to those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include: limiting or prohibiting communication with others when that communication would be harmful to the individual prohibiting unlimited access to food when that

Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Procedure #: BM.1.01

Issue Date: 1985

Rev. Date: 01/31/17

Page: 13 of 14

NOTE: This Document Copy is Uncontrolled and Valid on this date only: February 16, 2017. For Controlled copy, view shared directory I:\ drive

access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques require the review and approval of the BTPRC.

- **Seclusion:** Refers to the placement of an individual in a room alone where egress is prevented by any means. Seclusion is **prohibited** except in 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.
- **Special Consent:** Refers to 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 generalized consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the recipient, guardian, or parent of a minor recipient may only occur when the recipient has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Michigan Mental Health Code.
- **Target Behaviors:** Refers to behavior or behaviors that are the focus of treatment in a behavior treatment plan.
- **Targeted Case Manager (CSM)/Supports Coordinator (SC):** The designated staff person whose primary function is to plan, coordinate, link, and monitor the delivery of services and supports which are identified in the individual's approved behavior treatment plan.

ACRONYMS:

AIMS – Abnormal Involuntary Movement Scale
AMA – American Medical Association
ASHP - American Society of Health-System Pharmacists
BBA - Balanced Budget Act
BTPRC – Behavior Treatment Plan Review Committee
DRA – Differential Reinforcement of Alternative Behavior(s)
DRH - Differential Reinforcement of High Rates of Behavior(s)
DRI - Differential Reinforcement of Incompatible Behavior(s)
DRL – Differential Reinforcement of Low Rates of Behavior(s)
DRO – Differential Reinforcement of Other Behavior(s)
EMR – Electronic Medical Record
FDA – Food and Drug Administration
HBH – Huron Behavioral Health
MDHHS – Michigan Department of Health and Human Services
MSHN – Mid-State Health Plan
PCP – Person Centered Plan
PDR – Physician's Desk Register
PIHP – Pre-Paid Inpatient Health Plan
RN – Registered Nurse

Forms:

DCH-0044 Incident Report Form (MDHHS Form)
[90-119 Psychotropic Medication Consent Form](#)
[90-421 Behavior Treatment Plan Form](#)
[90-475 Behavior Assessment Form](#)

Records:

- Behavior Plans are retained in the consumer's case record in accordance with the [HBH Record Retention and Storage Policy \(QI.1.23\)](#).
- Completed incident reports are maintained by the HBH Recipient Rights Officer in accordance with the [Recipient Rights – Record Retention and Disposal Procedure \(RR.2.25\)](#).

Title: Behavior Treatment Plan PolicyProcedure #: **BM.1.01**

Issue Date: 1985

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

Rev. Date: 01/31/17

Page: 14 of 14

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: February 16, 2017**. For Controlled copy, view shared directory I:\ drive**Reference(s) and/or Legal Authority**[MDHHS Contract Attachment C.6.8.3.1](#)

Michigan Mental Health Code Public Act 258 of 1974

Chapter III of the Michigan Medicaid Manual

Michigan Department of Health and Human Services (MDHHS) Service Standards and Requirements

Michigan Mental Health Code

MDHHS Technical Requirement for Behavior Treatment Plan Review Committees

Federal Balanced Budget Act

MSHN Behavior Treatment Plans Policy adopted 07/01/14

COA Standards

[BM.1.03 Emergency Physical Interventions / Non Violent Crisis Interventions \(NVC\) Policy](#)[BM.2.01 Behavior Treatment Plan Review Committee \(BTPRC\) Procedure](#)[BM.2.02 Creation, Review, and Implementation of the Behavior Treatment Plan Procedure](#)[PPM.00 Employee Handbook](#)[QI.1.23 HBH Record Retention Policy](#)[RR.1.01 Limited English Proficiency \(LEP\) Policy](#)[RR.2.15 Psychotropic Medications Procedure](#)[RR.2.25 Recipient Rights – Record Retention and Disposal Procedure](#)**Change History:**

Change Letter	Date of Change(s)	Changes
A	05/13/03	Brought old document into new format and controlled documentation system, minimal changes to content.
B	02/11/04	Removed several sections and placed them into two additional policies/procedures (BM.1.02 and BM.2.02), removed corresponding definitions, removed references, clarified information, modified wording to reflect Medicaid Guideline language, added and changed definitions to reflect MHC Administrative Rules & COA guidelines, removed "Level One", "Level Two", and "Level Three" sections under "Policy" and moved the information into the "Definitions" section.
C	03/01/04	Revised to include recommendations from MDCH Recipient Rights Office. Changed "Mechanical Restraint" to "Restraint" in "Policy" section, removed item "c. Isolation" from Policy section, removed "Isolation" and "Time-Out" from "Definitions" section (DCH considers Isolation and Seclusion to be the same), changed definitions for "Seclusion" and "Restraint" to comply with the definitions in the Mental Health Code and the Administrative Rules.
D	02/10/05	Added g-j under prohibited techniques, added "Restrictive Techniques" to "Definitions" section
E	03/06/06	Added "Time Out" to Definitions to comply with Administrative Rule definition, added second bullet in "Records" section, added reference to RR.2.25, added hyperlinks.
F	02/25/08	Total re-write of policy to comply with regionally adopted policy (Chapter 4; Section 8; Topic 1)
G	04/06/09	Reviewed and revised to comply with COA 8 th Edition Standards and present practices. Removed COA chapter-specific reference (G10, G2.5.03, G9.2), re-ordered section A.1 alphabetically and added A.1.j "Isolation" & added COA definition, added "or Locked Seclusion" in A.1.o & added last sentence in A.1.o, added last sentence in D. (Staffing Levels), added paragraph in "Information" section, added last sentence in "Scope" section, added "Chemical Restraints" and "Manual Restraint" to "Definitions" section, added second-to-last bullet in "Definitions" section, removed section #6 "Planned Physical Interventions", reworded 5.c to remove one bullet & statement about interventions uncomfortable but outweighing the risk, added last sentence in 5 th bullet in B.9.d, removed "Planned Physical Intervention" in Table "Level III Procedures", added last sentence in 2 nd paragraph in B.6. added #1, #3, & #4 in "Information" section, in "Definitions" section, added "Intrusive techniques", "Peer reviewed literature", "Physical Management", "Positive behavior support", "Practice or treatment guidelines", "Restraint", "Restrictive techniques", "Seclusion", & "Special consent" to match MDCH definitions
H	12/03/09	To comply with non-compliance findings of the 2009 AAM Delegated managed care Audit, added "90-475 Behavior Assessment Form" to "Forms" section
I	08/30/12	Revised policy to comply with regional (AAM) changes to Technical Requirement "3-1 Behavior Treatment Plans" approved by Leadership Council on 07/17/12. Made numerous content changes to comply with new technical requirements – See QI Coordinator for marked version of old policy.
J	08/27/14	Reviewed and revised to comply with MSHN policy "Behavior Treatment Plans" adopted 07/02/14 and MDCH contract requirement C6.8.3.1 – revised several definitions to match exact wording in C6.8.3.1 and added "Consent", "Functional Behavior Assessment", "Emergency Interventions", and "Imminent Risk" to "Definitions" section, removed "AAM- Access Alliance of Michigan" from "Acronym" section, removed reference to "AAM" throughout document (4 places), added reference to MSHN in "Purpose" section, added "MSHN" in "Acronym" section.
K	03/24/15	In "Policy" section removed A.1.b as this was duplicated in A.1.n, corrected page numbers, no other content changes made.
L	01/31/17	Changed "Michigan Department of Community Health/MDCH" to "Michigan Department of Health and Human Services/MDHHS" throughout document (9 places), combined the two tables labeled "Behavior Modification – Intrusive and restrictive Procedure" into one table, re-alphabetized and removed "Response Blocking for self-injurious behavior", in "Information" section added #8, in C.1 added last sentence, in F.3 added last sentence, in table labeled "Behavior Modification Procedures" added "Positive Practice", in "Other Voluntary Techniques" added 3 rd & 4 th bullets, made numerous wording/grammatical changes/corrections throughout document without changing sentence content, see Controlled Documentation Manager for list of changes and/or old revisions of this policy.