Title: Behavior Treatment Plan Policy

Prepared By: Behavior Treatment Plan Review Committee (BTPRC)

NOTE: This Document Copy is **Uncontrolled and Valid on this date only: March 10, 2025**. For Controlled copy, view shared directory I:\ drive

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 standards and technical requirement for behavior treatment plans, and the Council on Accreditation (COA) standards.

Scope:

This policy applies to all HBH Programs and all employees (including full-time and part-time employees), contract 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 a behavior treatment plan. 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, to promote dignity and respect, 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 limiting 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.
2. Behavior treatment plans must be developed through the person-centered planning process and be approved through special consent 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.
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 limiting and/or intrusive 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 (e.g., 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, limiting and/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 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. Limiting and/or intrusive 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 imminent 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 imminent risk of physical harm, HBH will develop an individual behavior treatment plan to ameliorate or eliminate the need for the limiting 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 limiting 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 techniques**: Any technique 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 (e.g., 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** – e.g., 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.

h. **Forced Physical Exercise to Eliminate Behaviors** – e.g., making an 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. **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 technique is prohibited under any circumstances.

l. **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.

m. **Psychosurgery** - Brain surgery used to treat severe, intractable mental or behavioral disorders.

n. **Restraint** - The use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.

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. In accordance with MDHHS Technical Requirements, Huron Behavioral Health will ensure that behavior treatment planning services are available to individuals who exhibit seriously aggressive, self-injurious, or other challenging behaviors that place the individual or others at imminent risk of physical harm.
2. Behavior treatment plans shall be written, implemented, and monitored in compliance with HBH policies, as well as MSHN policy and MDHHS Standards, and federal guidelines and standards defined in this policy using the "HBH Behavior Treatment Plan Form" (90-642). HBH staff shall utilize the least limiting/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 limiting and/or intrusive procedures. A formal written behavior treatment plan is necessary when medications are given for behavior control and/or for the purpose of behavior management.
3. 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. 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 himself/herself or others, or who engages in serious property destruction likely to result in harm to self or others. In all cases, including for unprecedented or unpredicted crisis or emergency, a hierarchy of least limiting 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 likely to result in harm to self or others. The completed incident report form must be submitted to the HBH Recipient Rights Officer. See also "Unusual Incident Reporting Procedure" RR.2.37).
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. Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should the same consumer repeatedly require the use of emergency physical intervention or law enforcement engagement (i.e., more than 3 times in a 30 day period), the treatment team will meet to address the use of the emergency procedures, evaluate the IPOS through the person-centered planning process, 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 ensure that foods which are be 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.

D. Behavior Treatment Plan Standards:

1. The person-centered planning process is used in the development of an individualized written plan of service. (see also "Person-Centered Planning Policy QI.1.05 and "IPOS Procedure" QI.2.18) and will identify when a behavior treatment plan is needed. Prior to the development of a formal behavior treatment plan, a functional assessment is conducted to rule out physical, medical, or environmental causes of the behavior (e.g., trauma, interpersonal relationships, etc.); and what unsuccessful attempts using positive behavioral supports and interventions have been made to change the behavior.
2. Behavior Treatment Plans (BTP) must employ positive behavior supports and interventions using applied behavior analysis (ABA) or other evidence-based practices, including specific interventions designed to develop functional abilities in major life activities. BTP's should also consider other kinds of behavior treatment interventions that are supported by peer-reviewed literature or practice guidelines and have written consent by the individual, his/her guardian, or parent with legal custody of a minor child prior to implementation of the plan. Any BTPs that include the use of physical management, aversive techniques, seclusion, restraint, or requesting involvement of law enforcement are prohibited from being included in the BTP and will not be approved.
3. Recipient Rights standards are to be adhered to in order to support and enforce this policy. Recipients have the right to a thorough habilitation program designed to help them to progress to a less restrictive setting.
4. Behavior treatment plans shall not include physical management in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law. Behavior treatment plans that include such interventions will be disapproved by the BTPRC.
5. Behavior treatment plans that propose the use of limiting or intrusive techniques as defined by this policy must be reviewed and either approved or disapproved by the BTPRC.
6. Staffing ratios and training will be adequate for implementation of the behavior treatment plan.
7. 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 target behavior
   b. A functional assessment
   c. Results of inquiries about any medical, psychological, or other factors that might put the individual subjected to limiting or intrusive techniques at high risk of death, injury, or trauma

d. Documented 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 in reducing/eliminating the behaviors within the last twelve (12) months

e. Evidence of continued efforts to find other options

f. Peer reviewed literature or practice guidelines that support the proposed use of limiting or intrusive techniques

g. References 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. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.

h. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s) including who is to provide the training and how it will be monitored

8. 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).

E. 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. • 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. ***Differential Reinforcement of Other Behavior(s) (DRO) -*** is a procedure where any behavior other than the target behavior is reinforced on a periodic schedule ***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 ***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 ***Differential Reinforcement of Low Rates of Behavior(s) (DRL) -***is a procedure where the infrequent occurrence (rate) of a target behavior is reinforced ***Differential Reinforcement of High Rates of Behavior(s) (DRH) -*** is a procedure where the frequent occurrence (rate) of a target behavior is reinforced
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 limiting.
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 behavior. Prompts may be verbal, gestural, or involve physical guidance. 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-limiting 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 assure 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: ▪ 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 IPOS) ▪ 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 – Limiting and/or Intrusive:

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, limiting or intrusive 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 limiting techniques will be followed. Limiting or intrusive 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 limiting or 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**. The BTPRC shall review all limiting and/or intrusive procedures and these procedures must be authorized by the BTPRC in writing before they may be implemented.**

Behavior Modification – Limiting and Intrusive and 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 limiting intervention.
Other Techniques –	These additional limiting and/or intrusive procedures also require BTPRC review and approval when included as part of a formal Behavioral Treatment Plan: • 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 • 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 target behaviors, the consumer's case record shall document the fact that less limiting 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 treatment plan. It is designed by the person centered treatment team to lead to a less limiting way of treatment, and ultimately to the reduction and/or elimination of medications being utilized.

A Psychiatric Evaluation should be conducted 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 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 must be obtained prior to administration of the medication.
- 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 target 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".)
- 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.

F. Written Special Consent:

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

Definitions/Acronyms:

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

- *Anatomical support:* refers to body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.
- *Applied Behavior Analysis (ABA):* 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 targeted 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 an individual'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, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.
- *Aversive Techniques:* refers to those techniques that require the deliberate infliction of unpleasant stimulus (stimuli which would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) to achieve the management, or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to consequate target behavior or to accomplish a negative association with a target behavior. And use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Note: 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, taking a prescription medication to help quit smoking) are not considered aversive techniques. 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 Treatment Plan Review Committee (BTPRC):* A specially constituted committee whose primary function is to oversee the proposed use of any limiting and/or intrusive 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. 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.

- *Bodily function:* refers to the usual action of any region or organ of the body.
- *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.
- *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. All interventions must comply with chapter 7 of the Michigan Mental Health Code and associated administrative rules. HBH has defined the protocols that may be used in "Emergency Physical Interventions / Non Violent Crisis Interventions (NVCI) Policy" BM.1.03.
- *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 treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the target 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 target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need. Functional assessment as should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.
- *Imminent Risk*: refers to an event/action that is about to occur that will likely result in the serious physical harm of one's 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 or control 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 of the BTPRC Committee.
- *Limiting Techniques:* refers to those techniques, that when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balance Budget Act. Examples of such techniques as limiting are prohibiting communication with others when that communication would be harmful to the individual; access to personal property that when that access would be harmful to the individual; or any limitation of freedom of movement of an individual for behavioral control purposes. Use of any intrusive techniques for behavior control purposes requires the review of the BTPRC committee.
- *Medical and dental procedures restraints:* refers to 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.
- *Person-Centered Planning*: means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
- *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 to prevent the individual from seriously harming himself, herself, or others. Note: 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 (NVCI) Policy).

- *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 targeted 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, and property destruction. 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.
- *Prone Immobilization:* - refers to extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control. Note: **PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES**
- *Protective Device*: refers to a device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device incorporated in written individual plan of service shall not be considered a restraint as defined in below.
- *Psychotropic drug*: refers to any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior
- *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 device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.
- *Seclusion:* refers to the temporary placement of an individual in a room, alone, where egress is prevented by any means. Seclusion is **prohibited** except in a hospital or unit 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.
- *Serious Physical Harm*: means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
- *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 limiting or intrusive techniques 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 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.

- *Support Plan*: refers to a written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.
- *Target Behaviors:* Refers to behavior or behaviors that are the focus of treatment in a behavior treatment plan.
- *Therapeutic de-escalation:* refers to an intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the re3cipient 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.
- *Time out:* refers to a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
- *Treatment Plan*: refers to a written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.
- *Unreasonable force:* refers to physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:
    1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
    2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
    3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
    4. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

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
FBA – Functional Behavioral Assessment
FDA – Food and Drug Administration
HBH – Huron Behavioral Health
IPOS – Individual Plan of Service
MDHHS – Michigan Department of Health and Human Services
MSHN – Mid-State Health 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
90-642 Behavioral 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).

Reference(s) and/or Legal Authority

MDHHS Contract
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 Standards 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 (NVCI) 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.1.05 Person-Centered Planning Policy
QI.1.23 HBH Record Retention Policy
QI.2.18 Individual Plan of Service (IPOS) Procedure
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 8th 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 5th bullet in B.9.d, removed "Planned Physical Intervention" in Table "Level III Procedures", added last sentence in 2nd 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 3rd & 4th 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 to this policy.
M	12/12/17	Changed "behaviors" and "problem behaviors" to "target behaviors" throughout document, changed MDHHS "technical requirements" to "MDHHS standards" throughout document, in "Definition" section added "Anatomical support", "Bodily function", "Emotional harm", "Medical and dental procedures restraints", "Person-centered planning", Prone immobilization", "Protective device", "Psychotropic drug", "Serious physical harm", "Support plan", "Therapeutic de-escalation", "Time out", "Treatment plan", "Unreasonable force", made numerous small wording/grammatical changes/corrections throughout document without changing sentence content.
N	09/24/19	Reviewed by Clinical Director – no content changes made.
O	08/17/21	In "Acronyms" section removed "PCP" & added "IPOS", in "References" section added QI.1.05 & QI.2.18, in D.1 & D.2 added "destruction likely to result in harm to self or others", made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
P	10/11/21	Made numerous deletions and additions to align with MDHHS requirements, also made numerous minor wording/grammatical changes/corrections throughout policy without changing sentence content. (See Controlled Documentation Manager for list of changes and/or previous versions of this policy.)
Q	08/28/23	In "Acronyms" section added "FBA", made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
R	01/29/25	Changed "restrictive and/or intrusive" to "limiting and/or intrusive" throughout policy (33 places) to comply with revisions to MSHN policies and MDHHS "Technical Requirement for Behavior Treatment Plans" dated September 13, 2024, in "Policy" section added D.2, in "Definitions" section revised "Applied Behavioral Analysis" and removed "Behavior Assessment", "Behavior Management", "Behavior Modification",, "Emotional Harm", "Peer-Review Literature", "Restrictive Techniques", Targeted Case Management", made numerous minor wording/grammatical changes/corrections throughout policy without changing sentence content.