St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

Administrative Policy

Policy Title:	**Behavior Treatment Plan Review**
Policy #:	**02-003-0025**
Effective Date:	06/5/2025
Approved by:	Telly Delor, Chief Operating Officer
Functional Area:	Utilization Management
Responsible Leader:	Kathleen Gallagher, Chief Clinical Officer
Policy Owner:	Service Directors
Applies to:	Community Agency Contractor, Contracted Network Providers, Directly Operated Programs, Specialized Residential Providers, SCCCMH Staff, SCCCMH Board

Purpose: The purposes of this policy are:

- To protect individuals from inappropriate and unnecessary restrictive or intrusive interventions.
- To describe how treatment plans with restrictive or intrusive interventions are developed and approved, including the use of comprehensive assessments and review by the St. Clair County Community Mental Health Behavior Treatment Plan Review Committee.
- To describe general standards of behavioral management and emergency behavioral management.

I. Policy Statement

It is the policy of St. Clair County Community Mental Health (SCCCMH) to ensure that all individuals with treatment plans that include aversive, intrusive, and *restrictive techniques* align with Michigan Department of Health and Human Service (MDHHS) and Region 10 Prepaid Inpatient Health Plan (PIHP) guidelines. Treatment plans shall be developed using the Person-Centered Planning (PCP) process, which shall determine whether a comprehensive assessment should be done to rule out any physical or environmental causes for behaviors. Such treatment plans must undergo *Behavior Treatment Plan* Review for approval (or disapproval) by an appropriately constituted body, known as the Behavioral Treatment Plan Review Committee (BTPRC). SCCCMH shall also ensure that all deaths of beneficiaries who at the time of their death were receiving SCCCMH services be reviewed.

II. Standards

A. SCCCMH shall have a Committee (BTPRC) to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit, or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with SCCCMH and does not have its own Committee may have access to and use the services of the SCCCMH BTPRC Committee regarding a behavior treatment plan for an individual receiving services from SCCCMH. (See Administrative Policy #03-001-0060, Behavior Treatment Plan Review Committee.)

B. The *Behavior Treatment Plan Review Committee* (BTPRC) shall be comprised of at least three individuals, one member of whom shall be a Board-Certified Behavior Analyst as defined in Section 18.12 of the Medical Provider Manual Behavioral Health Treatment Services Applied Behavior Analysis Chapter, or a fully or limited Licensed Psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter with the specified training; preferably experience in applied behavior analysis. At least one member shall be a licensed Physician/Psychiatrist as defined in the Mental Health Code at MCL 330.1100c(1 0); and a representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other nonvoting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed.

C. SCCCMH shall use the Person-Centered Planning process used in the development of an individualized written plan of services. To identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical, or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the behavior.

D. Behavior Treatment Plans must be developed through the Person-Centered Planning process and written *special consent* must be given by the individual, or their guardian on their behalf if one had been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions. (See clinical advisories on Positive Behavioral Supports and Quick Guide to Writing a Behavioral Plan - Exhibit A).

E. Behavior Treatment Plans that propose to use *physical management* and or involvement of law enforcement in a non-emergent situation; *aversive techniques*; or *seclusion* or *restraint* in a setting where it is prohibited by law shall be disapproved by

the BTPRC. Should utilization of physical management or use of law enforcement occur more than three (3) times within a 30-day period, the individual's written IPOS must be revisited through the Person-Centered Planning process and modified accordingly if needed. MDHHS and Department of Human Services Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the *imminent risk* of serious or non-serious physical harm to the individual or other, approved emergency interventions may be implemented.

F. Behavior Treatment Plan services shall be actively designed to maximize the growth and development of the individual; thereby reducing *maladaptive behaviors*, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal interactions.

G. Any member of the *Treatment Planning Team*, the Office of Recipient Rights, or the BTPRC may submit a written appeal of a committee decision to SCCCMH Chief Executive Officer. The final decision on all BTPRC recommendations shall rest with the SCCCMH Chief Executive Officer.

H. Once a decision to approve a restrictive / intrusive behavior treatment plan has been made by the Committee, and written special consent to the plan (see limitations in definition of special consent) has been obtained from: the individual, the legal guardian, the parent with legal custody of a minor, or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2]).

I. Reviews of *unexpected deaths* must include: *Sentinel events,* which include suicides and all deaths without natural medical justification.

J. General Standards of *Behavior Management*:

1. Adaptive behavior is fostered and maintained by certain factors, which shall be considered before employing any Behavioral Treatment Plan designed to alter maladaptive behavior. These include:
    a. Sufficient living area
    b. Nutritious diet
    c. Opportunity for structured activity with peers
    d. Effective sanitary process
    e. Available personal possessions

f. Communications by and with staff
g. Positive staff individual open for services interaction
h. Recognition of the individual open for services, as a valued and respected person
i. Current and updated medical exam
j. Safety factors

2. Behavior management techniques must emphasize the development of alternate adaptive behaviors, rather than merely the elimination or suppression of maladaptive forms.
3. All plans for behavior modification shall be designed in accordance with professional ethic codes/standards and currently accepted practice and research. Maximum respect for the individual's personal dignity and safety shall always be reflected.
4. The behavior management techniques utilized shall ordinarily be the least restrictive alternative available.
5. Aversive techniques shall not be used for the convenience of staff.
6. Physical, psychological, and verbal abuse are prohibited.
7. Seclusion, defined as a temporary placement of an individual alone in a room where egress is prevented by any means, is strictly prohibited from being used for behavior modification or management as dictated by the Mental Health Code.
8. The application of a Behavioral Treatment plan, in willful violation of provisions of this administrative directive, may be construed as constituting abuse.
9. SCCCMH will not tolerate violence perpetrated on the recipients of public behavioral health services in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, SCCCMH shall 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:
   a. Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
   b. Employs Positive Behavior Supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
   c. 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 interventions nor other kinds of interventions were successful, proposes restrictive or *intrusive techniques*; described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

K. Emergency Techniques:

1. The SCCCMH Board recognized that a behavior management technique, such as manual restraint, physical restraint, or program suspension may be used in emergency situations summarized as follows:
   a. Emergency Behavioral Management interventions should only be employed when absolutely necessary to protect the individual from injury to themselves and others.
   b. If physical management/restraint techniques are necessary, they should only be employed by staff trained in the use of physical management (certified as passing the Positive Behavioral Supports & Prevention Strategies, and Nonviolent Crisis Intervention [CPI] training modules).
   c. Use of such practice should only continue until the challenging behavior no longer poses imminent safety risk.
   d. The program staff should notify the Program Supervisor immediately; form #0057 Incident Report must be completed and routed within 24 hours. These incident reports are reviewed by the Office of Recipient Rights and reported monthly to the BTPRC.
   e. Notification of additional parties (home, family, guardian, etc.) should also be considered for appropriate action.
   f. Should a pattern of continual challenging behavior which requires emergency intervention emerge or be anticipated, a Person-Centered-Planning meeting should be convened to consider:
      1) A new Behavioral Plan
      2) Alternative SCCCMH programs or services

L. Behavior Treatment Plans shall be written by qualified staff, approved by the Planning Team, and implemented only as an integral part of a person-centered plan in the context of a total treatment program which emphasizes habilitation, not only the reduction of challenging behavior.

M. Behavioral Treatment Plan utilizing aversive techniques shall also include provisions for teaching and positively reinforcing adaptive behavior. Alternate adaptive behaviors must be operationally defined, and a frequency record kept.

N. The Behavioral Treatment Plan shall follow the following format:

1. Behavioral Assessment
    a. Identifying information
    b. Current target behavior
    c. Behavioral summary
    d. Functional analysis
    e. Summary/signatures
2. Behavioral Treatment Goals/Objective
    a. Criteria
    b. Implementation procedures
    c. Intervention techniques
    d. Documentation requirements
    e. Training requirements
    f. Clinical responsibilities

O. The Behavioral Treatment Plan must be signed, with credentials, and dated by: 1) the qualified program director, and 2) the supervising Psychiatrist/Physician, with a statement indicating both approval of the plan and that the proposed intervention technique(s) is (are) not medically contraindicated.

P. Plans that are forwarded to the BTPRC for review shall be accompanied by:

1. Results of assessments performed to rule out relevant physical, medical, and environmental causes of the challenging behavior.
2. A functional behavioral assessment.
3. 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.
4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope, and duration that have been attempted to ameliorate the behavior, and have proved to be unsuccessful.
5. Evidence of continued efforts to find other options.
6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
7. References to the literature should be included on new procedures, 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 researched and utilized within most behavior treatment plans is not required.

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

III. Procedures, Definitions, and Other Resources

A. Procedures

Actions – Intrusive / Aversive / Restrictive Plans

Action Number	Responsible Stakeholder	Details
1.0	Primary Caseholder / Program Designer / Clinician	1. Complete form #0313 Behavior Treatment Plan Review Committee (BTPRC) Referral and send with required materials attached to supervisor for review and approval. 2. Present at BTPRC meeting and provide rational for request to seek committee approval ensuring functional behavioral assessment has been completed and that medical has been ruled out prior to committee review. 3. Obtain required signatures on form #0025C Special Consent Behavior Treatment Intervention after plan has been BTPRC-approved and prior to plan implementation. 4. Amend treatment plan to include approved BTPRC interventions and add authorizations. 5. Complete monthly, form #0124 Periodic Review Sheet for BTPRC Behavior Plans, and complete quarterly, form #0125 Positive Behavior Supports Survey with individual/guardian input. 6. Present at BTPRC meeting at the frequency determined by committee as outlined within BTPRC standards.
2.0	Program Supervisor	7. Review form #0313 Behavior Treatment Plan Review Committee (BTPRC) Referral and attachments. 8. Forward the approved form #0313 BTPRC Referral and attachments to Chief Clinical Officer. 9. Complete Case Consultation Note with caseholder on a monthly basis.
3.0	Chief Clinical Officer/Designee	10. Approve or disapprove form #0313 BTPRC Referral. 11. Sign approved form #0313 BTPRC Referral and forward with attachments to BTPRC clerical for addition to agenda on next regular BTPRC meeting
4.0	Primary Caseholder / Program Designer / Clinician	12. Attend the BTPRC and present the proposal and Periodic Reviews document(s), as applicable.

Actions – BTPRC Responsibilities

Action Number	Responsible Stakeholder	Details
1.0	BTPRC Chairperson	1. Send and document a date to re-examine approved plans for the continuing need for the approved procedure. This re-review shall occur no less than quarterly from the date of the last review or more frequently if clinically indicated for the individual's condition OR when the individual requests the review as determined through the person-centered process. 2. Schedule and conduct meetings of the Committee and distribute Minutes. 3. For emergent situations where an expedited review of proposed plan to use restrictive or intrusive interventions is needed, BTRPC chair in consultation with Recipient Rights Officer and Medical Director (when available), will review approve/disapprove proposed plan.
2.0	Office of Recipients Rights	4. Complete quarterly BTPRC Activities committee report. 5. Complete and present BTPRC Waiver and Risk Events reports with analysis and recommendations at SCCCMH BTPRC and QIC.

B. Related Policies

Administrative Policy #03-001-0060, Behavior Treatment Plan Review Committee

Board Policy #05-001-0016, Sentinel Events, Critical Incidents and Risk Events

C. Definitions

1. *Anatomical Support:* Body positioning or a physical support ordered by a physical occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.
2. *Aversive Techniques:* Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to cons equate 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 cons equating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure

therapy for anxiety, masturbatory satiation for paraphilia's) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.

3. *Baseline:* The period of time during which a behavior is observed and measured without any therapeutic or instructional intervention. This is used to determine a level for comparison or change.
4. *Behavior Assessment:* A component of the Behavior Treatment Plan that summarizes current maladaptive behaviors, antecedents and consequences of the behaviors, and desired target behaviors.
5. *Behavior Management:* The exercise of general control of behavior to achieve therapeutic objectives through the use of a variety of recognized techniques based on general behavior theory.
6. *Behavior Modification / Behavioral Tailoring:* The development of adaptive behavior and/or the elimination of maladaptive behavior to achieve therapeutic objectives through the systematic application of a variety of recognized techniques based on general behavior theory.
7. *Behavior Treatment Goals:* A component of the Behavior Treatment Plan. For purposes of this administrative procedure, means the specific PCP goals relating to the acquisition of a specific adaptive behavior (s) and/or the amelioration of a specific maladaptive behavior(s). The Behavior Treatment Goals must 1) be written by a qualified staff (see definition); 2) specify the specific objectives, methodologies, timelines, supervising professional, and termination criteria; 3) be incorporated into the individual's PCP; and 4) be approved by the PCP Team with the individual and/or empowered guardian.
8. *Behavior Treatment Plan Review Committee (BTPRC):* A specially constituted body that is designated to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. The BTPRC is comprised of at least three individuals. One member shall be a Board-Certified Behavior Analyst as defined in Section 18.12 of the Medical Provider Manual Behavioral Health Treatment Services Applied Behavior Analysis Chapter. Or a fully or limited Licensed Psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter, with the specified training; preferably experience in applied behavior analysis. At least one member shall be a licensed Physician/Psychiatrist as defined in the Mental Health Code at MCL 330.11 00c(1 0); and a representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee.

9. *Behavior Treatment Plan:* The systematic application of principles of general behavior theory to the development of adaptive and/or elimination of maladaptive behavior consistent with therapeutic objectives. The Behavior Treatment Plan has two components, a Behavioral Assessment and Behavioral Treatment Goals. Plans that utilize aversive, intrusive, and/or restrictive intervention techniques must be reviewed by the BTPRC.
10. *Bodily Function:* The usual action of any region or organ of the body.
11. *Emotional Harm:* Impaired psychological functioning, growth, or development of a significant nature as evidence by observable physically symptomatology or as determined by a mental health professional.
12. *Imminent Risk:* An event/action that is about to occur that will likely result in the potential harm to self or others.
13. *Individual Plan of Service (IPOS):* A written interdisciplinary service plan which identifies the specialized mental health services (including behavior management) and ancillary service needs of a person receiving services, and summarizes the habilitation and rehabilitation goals, objectives, methodologies, and expected outcomes for specified service and follows Person-Centered Planning guidelines.
14. *Intrinsic Risk:* Any treatment procedure, which carries an aversive degree of risk to the consumer and/or departs from the application of established and accepted techniques.
15. *Intrusive Techniques:* Those techniques that encroach upon (in other words, take over) 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 Committee.
16. *Maladaptive Behavior:* Any behavior, which poses a danger to the individual or others, which interferes significantly with the individual's ability to learn adaptive skills, or which substantially reduces the individual's access to community resources.
17. *Medical and Dental Procedures Restraints:* 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 restraints shall only by be used as specified in the individual's written plan or services for medical or dental procedures.

18. *Peer-reviewed literature:* Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.
19. *Physical Management:* A technique used by staff (as an emergency intervention) to restrict the movement of an individual by continued direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. Physical management, as defined here, shall not be included as a component of a behavior treatment plan, and should only be used when less restrictive interventions are ineffective to deescalate serious risk. The term "physical management" does not include briefly holding an individual in order to comfort them or to demonstrate affection or holding their hand. Physical management involving prone immobilization is prohibited under any circumstances.
20. *Positive Behavior Support (PBS):* A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other challenging 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 decrease challenging behaviors. PBS are most effective when they are implemented across all environments, such as home, school, work and in the community.
21. *Practice or Treatment Guidelines:* Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
22. *Protective Device:* A device or physical barrier to prevent the recipient form causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined below.

23. *Restraint:* The use of physical or mechanical device to restrict an individual's movement at the order of a physician. This definition excludes anatomical or physical supports or protective devices. This definition excludes anatomical or physical supports that are ordered by a physician. The definition also excludes safety devices required by law, such as car seat belts or child car seats used while riding in vehicles. The use of physical or mechanical devices used as restraint is prohibited except in a state-operated facility or a licensed hospital.
24. *Restrictive Techniques:* Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. For example, restrictive 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. These include, limiting or prohibiting communication with others when that communication would be harmful to the individual, prohibiting unlimited ordinary access to food (excluding dietary restrictions that 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 requires the review and approval of the Committee.
25. *Safe Area:* Any specific area that has been determined to promote a sense of well-being and decrease agitation or aggressiveness in a given individual. Several safe areas may be identified for a given individual with each safe area being used for a different specified circumstance. Usually, the safe area and its use will be clearly identified in the IPOS, but in emergency situations, a safe area may be identified de novo. A safe area is typically part of the usual living space of an individual or is similar in comfort to that living space. Individuals with the potential to cause harm shall identify (along with the treatment team) safe areas, which will decrease the potential for harmful behavior. The safe areas shall be clearly described in the IPOS.
26. *Seclusion:* The placement of an individual in a room alone where egress is prevented by any means. Seclusion is prohibited except in a hospital or center operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.
27. *Seclusion vs Physical Restraint:* The Michigan Mental Health Code defines both seclusion and physical restraint but allows for some overlapping areas with regard to limiting an individual's freedom of movement. The Code defines an individual's right to freedom of movement and to safety. It is unacceptable to lock an individual in any room because this has the effect of denying an individual freedom of movement without the obvious, immediate, and ongoing need for safety. On the other hand, physical restraint is permitted to keep an

individual safe when an obvious and immediate threat to safety is ongoing even though such restraint denies freedom of movement. The close proximity of the staff applying physical restraint appears to be the critical factor making this infringement on the individual's freedom more acceptable than seclusion. Staff presumably are better able to assess the effect of the restraint on the individual's behavior and mood due to this close physical proximity to the individual. On the other hand, seclusion assumes that the individual is locked in a room with no guarantee that a staff person is near enough to adequately assess the effect of the isolation on the individual. Seclusion is forbidden.

28. *Sentinel Event:* An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant change of a serious adverse outcome (JCAHO 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. (See Board Policy #05-001-0016, Sentinel Events, Critical Incidents and Risk Events).
29. *Special Consent:* Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the 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 Mental Health Code.
30. *Time-Out:* A negative reinforcement technique (in other words, the conditional removal of something an individual identifies as unpleasant or unwanted) which moves an individual from an environment that is stimulating dangerous behavior in the individual to a safe area which increases the likelihood of less dangerous behavior. Time-out is a voluntary response to the therapeutic suggestion to an individual to remove themself from a stressful situation in order to prevent a potentially hazardous outcome.
31. *Treatment Planning Team:* A team composed of individuals whose membership is determined by the needs of the individual recipient. It is charged with the responsibility of ongoing recipient evaluation and the subsequent development and implementation of Person-Centered Plan. Membership may include: Case Manager (QMHP or QIDP), the identified individual and physician. It may also include: parent/guardian, Clinician (Psychologist, Licensed Social Worker,

Licensed Mental Health Counselor), Registered Nurse, Occupational Therapist, Residential program representative(s), and day program representative(s).

32. *Unexpected Death:* Those deaths that result from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. (See Board Policy #05-001-0016, Sentinel Events, Critical Incidents and Risk Events).

D. Forms

#0025C Special Consent Behavior Treatment Intervention

#0057 Incident Report

#0124 Periodic Review Sheet for BTPRC Behavior Plans

#0125 Positive Behavior Supports Survey

#0313 Behavior Treatment Plan Review Committee (BTPRC)

E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

Exhibit A: Quick Guide to Writing a Behavior Plan

F. References

1. Acts 258, Public Acts of 1996, as amended. Michigan Mental Health Code, Sections 700, 708,712, 740, 742, and 744.
2. Administrative Rules. Michigan Department of Mental Health, Rules: 7001, 7003, 7199, 7231 and 7253.
3. Federal Register, CMS. MEDICAID REGULATIONS, Section: Behavior Management I - VI.
4. MDHHS/CMHSP Mental Health Supports and Services Contract Attachment C6.8.3.1
5. Medicaid Manual: Behavioral Health and Intellectual and Developmental Disability Supports and Services Section 3.3.2.
6. Standards Manual and Interpretive Guidelines for Behavioral Health, CARF

IV. History

- Initial Approval Date: 08/2003
- Last Revision Date: 05/2025 BY:
- Last Reviewed Date: 05/2024 BY: Amy Kandell and Lonnie Sharkey
- Non-Substantive Revisions:
- Key Words: aversive, emotional, harm, intrusive, maladaptive, physical, restraint, restrict, restrictive, seclusion, technique