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

# Administrative Policy

**Policy Title:** **Behavior Treatment Plan Review Committee**

**Policy #:** **03-001-0060**

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| **Effective Date:** | 06/5/2025 |
| **Approved by:** | Telly Delor, Chief Operating Officer |
| **Functional Area:** | Treatment |
| **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:** To describe the structure and functions of a Behavior Treatment Plan Review Committee that will protect and promote respect for and dignity of all individuals who receive public behavioral health services by reviewing all proposals to use intrusive or restrictive interventions.

## I. Policy Statement

It is the policy of St. Clair County Community Health (SCCCMH) to have a *Behavior Treatment Plan* Review Committee (BTPRC) that approves or disapproves Behavior Treatment Plans that propose to use intrusive or restrictive interventions, with individuals who exhibit seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm. This policy shall include protocols for using the least intrusive and least restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all other non-emergent or continuing occurrences of these behaviors, BTPRC will ensure appropriate assessments and evaluations to rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.

## 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 SCCCMH and does

not have its own Committee may have access to and use the services of the SCCCMH Committee regarding a behavior treatment plan for an individual receiving services from SCCCMH.

**B.** The BTPRC shall be comprised of at least three individuals. One member shall be a Board Certified Behavioral Analyst as defined in Section 18.12 of the Medicaid 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(10); and one member shall be a representative of the Office of Recipient Rights and shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion, and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

**C.** The SCCCMH Office of Recipient Rights (ORR) representative shall attend all BTPRC meetings and receives Committee correspondences but is not an official member of the BTPRC.

**D.** BTPRC members, including the Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be reappointed to consecutive terms.

**E.** The BTPRC Chair shall secure a designated staff to the Committee on an as needed basis to perform related staff role functions (e.g., technical assessment, monitoring, technical information, agenda preparation, material distribution, committee activity analysis and recommendations). The Clerical Staff Support person will be a non-approving member of the Committee.

**F.** Alternate or Ad Hoc member(s) may be assigned to the BTPRC by the SCCCMH Chief Executive Director on a temporary basis to ensure appropriate representation for a specific area being reviewed.

**G.** All Committee members must complete orientation training prior to participation (i.e., review of policy and references). The Behavior Modification Specialist (individual developing the behavioral plan) shall have formal training and at least one year of experience in Applied Behavior Analysis. Such training shall have been at the graduate level at an accredited college or university and shall have included course credits covering theory, application, and practicum experience. In addition, such persons shall attend professional development (continuing education) programs in behavior management.

**H.** All decisions by the BTPRC shall require a majority of those approving members present. Approvals, modifications, and denials of any behavioral treatment plan must be documented in the official minutes.

**I.** The BTPRC shall meet as often as needed.

**J.** The BTPRC shall keep all its meeting minutes, and the Services Director, who is a member of the BTPRC will determine if further action is needed.

**K.** BTPRC members who has prepared a behavior treatment plan to be reviewed by BTPRC Committee shall recuse themselves from the final decision making.

**L.** The BTPRC must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. Expedited mean the plan is reviewed and approved in a short time frame such as, 24 or 48 hours.

1. The most frequently occurring example of the need for expedited review of proposed behavior treatment plans in emergent situations occurs as a result of the following AFC Licensing Rule: Adult Foster Care Licensing R400.14309 Crisis intervention:
    a. Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the [individual] requires the repeated or prolonged use of intervention procedures, the licensee must contact the [individual's] designated representative and the responsible agency….to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan.
2. Expedited plan reviews may be requested when, based on data presented by professional staff (psychologist, RN, supports coordinator, case manager), when the plan requires immediate implementation. The committee chair may receive, review, and approve such plans on behalf of the committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implantation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the committee.

**M.** BTPRC approved behavior treatment plans must include written consent from the individual, the legal guardian, the parent with legal custody of a minor, designated patent advocate via special consent (see definition of special consent) before the behavior treatment plan becomes part of the person's written IPOS.

Note: the individual, legal guardian, parent with legal custody or a minor child, or designated patient advocate has the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan.

**N.** Data on the use of *restrictive techniques* is to be evaluated by the Prepaid Inpatient Health Plan's Quality Assessment Performance improvement Program (QAPIP) or the SCCCMH Quality Improvement Program and be available for MDHHS review. Noted data shall be submitted to the PIHP and SCCCMH Quality Improvement Council (QIC) per reports: quarterly BTPRC, Risk Events, and BTPRC Spreadsheet.

**O.** Any member of the *Planning Team*, the Office of Recipient Rights, or the BTPRC may submit a written appeal of a Committee's decision to the SCCCMH Chief Executive Director. Final decision on all BTPRC recommendations shall rest with the SCCCMH Chief Executive Director.

**P.** *Sentinel Events* shall be reported monthly to the PIHP in accordance with the BTPRC's monthly meeting schedule.

**Q.** Risk Events shall be reported to the PIHP quarterly by event category along with plans of action or interventions, which occurred during the period. Reviews of unexpected deaths must include:

1. Screens of individual deaths with standard information.
2. Involvement of medical personnel in the mortality reviews.
3. Documentation of the mortality review process, findings, and recommendations.
4. Use of mortality information to address quality of care.
5. Aggregation of mortality data over time to identify possible trends. Such trend reports may include: contract review, Utilization Review and UM reviews.

**R.** The functions of the Committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use *aversive techniques*, *physical management* or *seclusion* or *restraint* in a setting where it is prohibited by law or regulations.
2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques.
3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent

implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

5. Assure that inquiry has been made about any known medical, psychological, or other factors that the individual has, which might put them at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. Provide an "Expedited" (within 24 to 48 hours) Review of Proposed Behavior Treatment Review Plans.
7. Review all potential *critical incidents* and determine if they meet the criteria of Sentinel Event.
8. Perform a Lethal Case Review on all incidents of individuals which resulted in death. (See Board Policy #05-001-0010, Death Reporting)
9. Participate in the PIHP QAPIP, or the SCCCMH Quality Improvement Program (QIP): for an evaluation of the committee's effectiveness by stakeholders including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individual served.
10. Ensure Root Cause Analysis is completed on all Sentinel Events. BTPRC to develop and implement either a) a plan of action or intervention to prevent further occurrence of Sentinel event: or b) presentation of a rationale for not pursuing an intervention.
11. Advise and recommend the need for specific staff or home-specific training in positive behavioral supports, and other evidence based and strength-based models individual-specific non-violent interventions.
12. Advise and recommend acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk or harm.
13. At its discretion, review other formally developed behavior treatment plans including positive behavioral supports and interventions if such reviews are consistent with the agency's needs and approved in advance by the agency.
14. Advise administrative and other policies affecting behavior treatment and modification practices.
15. Provide specific case consultation as requested by professional staff of the agency.
16. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
17. Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

18. Quarterly track and analyze the use of all physical management and involvement in law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, including:
    a. Dates and number of interventions used.
    b. The setting (e.g., individual's home or work) where behaviors and interventions occurred.
    c. Observations about any events, settings, or factors that may have triggered the behavior.
    d. Behaviors that initiated the techniques.
    e. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
    f. Description of positive behavioral supports used.
    g. Behaviors that resulted in termination of the interventions.
    h. Length of time of each intervention.
    i. Staff development and training, and supervisory guidance to reduce the use of these interventions.
    j. Review and modification development, if needed, or the individual's behavior plan.

**S.** 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, and where the intervention has limited or no support in the literature, why the plan is the best option available.
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 – Lethality Reviews

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| 1.0 | Primary Caseholder/ Program Designer/ Clinician | 1. Immediately upon notification of a death, complete form #0057 Incident Report, a Death Report in OASIS, and any other pertinent paperwork to close an individual's electronic health record in OASIS.<br>2. Complete form #0313 Behavior Treatment Plan Review committee (BTPRC) Referral with attached required materials then give documentation to supervisor for reviews and signature<br>3. Complete form #0123 Sentinel Event Root Cause Analysis (RCA) if case review indicates a Sentinel Event has occurred. |
| 2.0 | Supervisor | 4. Review Incident Report, Death Report, and form #0313 BTPRC Referral and sign, then forward documents to the Services Director<br>5. Ensure caseholder has completed form #0123 Sentinel Event Root Cause Analysis if requested by BTPRC. |
| 3.0 | Services Director | 6. Review form #0313 BTPRC Referral and confer with the recipient rights officer and BTPRC Chairperson to determine if Sentinel Event criteria has been met.<br>7. Route Sentinel Event documentation to BTPRC Chairperson<br>8. Route non-Sentinel Event documentation to BTPRC clerical to be added to next BTPRC agenda |
| 4.0 | BTPRC Chairperson | 9. Review chart documentation upon receipt of notification of a death.<br>10. Evaluate if there were behavioral health issues to address at BTPRC that may require systems improvements.<br>11. Coordinate with BTPRC clerical the addition of lethality case to be reviewed ensuring it is added to the agenda.<br>12. Facilitate the BTPRC meeting and review/approve meeting minutes.<br>13. Complete remaining section of form #0123 Sentinel Event RCA that includes committee disposition.<br>14. Submit quarter BTPRC Activities Reports to UM Team Leader.<br>15. Notify QIC / management of any behavioral health |

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| | | systems improvements needs identified by BTPRC. |
| 5.0 | BTPRC Clerical | 16. Contact Count Clerk Office for a copy of Death Certificate, upon notification of a death.<br>17. Contact Medical Examiner for a copy of autopsy report, when applicable.<br>18. Complete, per consultation with BTPRC chairperson, the agenda for all committee meetings.<br>19. Copy needed documents for meetings.<br>20. Complete BTPRC minutes.<br>21. Submit minutes to BTPRC chairperson for approval.<br>22. Maintain a file of BTPRC minutes, Periodic Review sheets, Sentinel Events, and other pertinent documentation.<br>23. Route BTPRC Chairperson signed minutes to applicable Data management staff for administrative file. |
| 6.0 | Office of Recipient Rights | 24. Complete and present at BTPRC monthly BTPRC, Waiver individuals, spreadsheet.<br>25. Complete and submit to R-10 PIHP monthly, Waiver individuals, spreadsheet.<br>26. Complete and submit to R-10 PIHP monthly Physical Management report.<br>27. Complete and present to BTPRC quarterly BTPRC Activities Report.<br>28. Complete and present to BTPRC Risk Events Analysis Reports with tables and graphs.<br>29. Report BTPRC Risk Events Analysis Report to QIC. |

## B. Related Policies

Board Policy #05-001-0010, Death Reporting

## 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. *Applied Behavior Analysis:* The organized field of study which has as its objective the acquisition of knowledge about behavior, using accepted principles of inquiry based on operant and respondent conditioning theory. It also refers to a set of techniques for modifying behavior toward socially meaningful ends based on these conceptions of behavior. Although this field of study is a recognized sub-specialty in the psychology discipline, not all practitioners are

psychologists, and such training may be acquired in a variety of disciplines.

3. *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) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is prohibited.
4. *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 (2) components, a Behavioral Assessment and Behavioral Treatment Goals. Plans that utilize aversive, intrusive, and/or restrictive intervention techniques must be reviewed by the BTPRC.
5. *Bodily Function:* The usual action of any region or organ of the body.
6. *Critical Incident:* Specific incidents/events that include: suicide, non-suicide death, hospitalization due to injury (including overdosing), serious illness requiring hospitalization, emergency medical treatment due to medication error, alleged case of abuse or neglect, serious challenging behavior, and arrest of individual.
7. *Emergency Interventions:* There are only two 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. SCCCMH shall have protocols specifying what physical management techniques are approved for use.
8. *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.
9. *Imminent Risk:* An event/action that is about to occur that will likely result in the potential harm to self or others.
10. *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 services and follows Person-Centered Planning guidelines.

11. *Intrusive Techniques:* Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at-risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control, or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
12. *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 of services (IPOS) for medical or dental procedures.
13. *Physical Management:* A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent the individual from physically harming themselves, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm and least restrictive interventions have been attempted and have been ineffective to deescalate serious risk. To ensure the safety of each individual and staff, SCCCMH has designated only approved emergency physical management interventions to be utilized during emergency situations. The term "physical management" does not include briefly holding an individual in order to comfort them or to demonstrate affection or holding their hand. The following are examples to further clarify the definition of physical management. Physical management shall not be used as a component of behavioral treatment plan.
    a. Manually guiding down the hand/fists of an individual who is striking their own face repeatedly causing risk of harm IS considered physical management if they resist the physical contact and continues to try and strike themself. However, it IS NOT physical management if the individual stops the behavior without resistance.
    b. When a caregiver places his hands on an individual's biceps to prevent them

from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

c. Come Along – when a caregiver physically guides a person in a direction they do not want to go and the person resists, it is considered physical management.

Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is prohibited under any circumstances. Prone immobilization is extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to their body in a manner that prevents them from moving out of the prone position.

14. *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.
15. *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 Individual Plan of Service. Membership may include: supports coordinator/case manager (QIDP or QMHP), person receiving services and physician. It may also include: parent/guardian, Clinician (psychologist, licensed social worker, licensed professional counselor), registered nurse, occupational therapist, residential provider/representative and daytime setting representative.
16. *Positive Reinforcement:* Any stimulus event, which increases the rate of a specific response.
17. Positive Behavior Support: A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious, or other behaviors that place the individual or others at risk of physical harm by conducting a functional assessment and teaching new skills and making changes in a person's environment. Positive behavior support

combines valued outcomes, behavioral, and biomedical science, validated procedures, and systems change to enhance quality of life and reduce challenging behaviors. Positive behavior supports are most effective when they are implemented across all environments, such as home, school, work and in the community.

18. *Practice or Treatment Guidelines:* Guidelines published by professional organizations such as the American Psychiatric Association (APA) or the federal government.
19. *Protective Device:* 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 as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined below.
20. *Proactive Strategies in a Culture of Gentleness:* Strategies within a Positive Behavior Support Plan used to present 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, validating feelings, providing choice, community inclusion and meaningful activities.
21. *Reactive Strategies in a Culture of Gentleness:* Strategies within a Positive Behavior Support Plan used to effectively respond when individuals begin feeling unsafe, insecure, anxious, or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking.
22. Restraint: The use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is prohibited except in a state-operated facility or a licensed hospital. This definition excludes:
    a. Anatomical or physical supports that are ordered by a physician, physical therapist, or occupational therapist for the purpose of maintaining or improving an individual's physical functioning.
    b. Protective devices, which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior. Furthermore, which are incorporated in the written individual plan of service through a behavior treatment plan, which has been reviewed and approved by the committee

and received special consent from the individual or their legal representative.

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

d. Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

23. *Request for Law Enforcement Interventions:* Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self- injurious or other behavior that places the individual or others at risk of physical harem. 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.

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

25. *Safe Area:* Any specific area which has been determined to promote a sense of wellbeing 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 (defined on an as needed basis). 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 planning 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. *Sentinel Event:* An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to an individual. 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. - An applicable individual is one who either lives in a 24 hour Specialized Residential Home or Child Caring Institution, lives in their own home and receives Personal Care services.
28. *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 restrictive -/- intrusive 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.
29. *Target Behavior:* A desired behavior that does not occur, but which is targeted to be established.

## D. Forms

#0057 Incident Report

#0123 Sentinel Event Root Cause Analysis (RCA)

#0313 Behavior Treatment Plan Review committee (BTPRC)

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

Exhibit A: BTPRC Incident/Lethal Case/Sentinel Event Review Form

Exhibit B: BTPRC Quarterly Activities Report

Exhibit C: Risk Events (Incidents) Analysis Report

Exhibit D: Risk Events Table Report

Exhibit E: PIHP R10 – BTPRC Spreadsheet

Exhibit F: St. Clair Physical Management Report

### 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, HCFA. MEDICAID REGULATIONS. Section: Behavior Management, I - VI.
4. 1997 Federal Balanced Budget Act at 42 CFR 438.100
5. MCL 330.1712; MCL 330.1740; MCL 330.1742, Michigan Mental Health Code
6. Department of Community Health Administrative Rule 330.7199(2)(g)
7. Standards Manual and Interpretive Guidelines for Behavioral Health, CARF.
8. MDCH/CMHSP Managed Mental Health Supports and Services Contract.

## IV. History

- Initial Approval Date: 10/1989
- Last Revision Date: 05/2025 BY: Heidi Fogarty, Jason Marocco, Kristen Thompson
- Last Reviewed Date: 05/2024 BY: Lonnie Sharkey and Amy Kandell
- Non-Substantive Revisions:
- Key Words: aversive, emotional, harm, intrusive, maladaptive, physical, restraint, restrict, restrictive, seclusion, technique, committee, behavior, treatment