BERRIEN MENTAL HEALTH AUTHORITY
-- PROCEDURE –

SUBJECT: BEHAVIOR TREATMENT COMMITTEE	SECTION: 01-03-02 Page 1 of 12
APPLICATION: All Consumers EFFECTIVE DATE: 04/01/94 APPROVED BY: _____ Chief Executive Officer REVISED: 9/94, 10/96, 4/98, 3/99, 5/99, 3/05, 5/05, 7/05, 3/06, 5/07, 9/07, 2/08, 6/08, 9/09, 8/10, 11/11, 7/13, 4/16, 2/17, 6/18, 2/19, 7/19, 10/20, 1/2021, 8/2021, 8/2022, 5/2023, 8/2023, 2/2024, 8/2025, 7/2026	REQUIRED BY: MHC ICF/MR Standards 42CFR 483-420

POLICY:
It is the policy of Berrien Mental Health Authority (BMHA) to protect and promote the dignity and respect of all individuals receiving public mental health services. BMHA conducts comprehensive psychological evaluations of individuals identified with serious challenging behaviors and develop treatment plans utilizing the Person Centered Planning Process to address these behaviors. When consumer behaviors are so severe that they need to be addressed, a Behavior Treatment Plan must be developed by a qualified clinician in conjunction with the primary clinician, home provider, family member and/or guardian if in place, and those implementing the plan. No restrictive behavior control recommendations can be made outside of the behavior treatment planning process. The Behavior Treatment Committee (BTC) is to conduct regularly scheduled meetings to review and provide oversight to those responsible for writing Behavior Treatment Plans.

PURPOSE:
To assure the least restrictive and intrusive interventions are utilized when intervening with an individual who exhibits seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. As well as, to ensure that consumers are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

STANDARDS:

1. The Michigan Department of Health and Human Services (MDHHS) will not tolerate violence perpetrated on the individuals served by the public mental health system 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, the public mental health agency 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
d. As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

2. MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code
3. It is the policy of MDHHS that all publicly supported mental health agencies shall use a specially constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards herein, including those for its appointment, duties, and functions.
4. BMHA shall have a Behavior Treatment Committee (BTC) 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 BMHA and does not have its own Committee must also have access to and use of the services of the BMHA BTC regarding a behavior treatment plan for an individual receiving services from BMHA. If BMHA delegates the functions of the Committee to a contracted mental health service provider, BMHA must monitor that Committee to assure compliance with these standards.
5. Any modifications to the Home and Community Based Services Final Rule (HCBS) shall be outlined in the Individual Plan of Services. If the modification imposes limitations or restrictions due to behavioral issues, the individual shall be referred for review by the BTC. If appropriate, a formal Behavioral Treatment Plan (BTP) will be implemented and reviewed regularly by BTC.

Behavior Treatment Plans shall be at a minimum updated annually. Behavior Treatment Plans shall be presented for review of the Behavior Treatment Committee on a minimum of a quarterly basis, or as directed by the BTC. If an individual's behaviors change significantly, the Behavior Treatment Plan can be brought to the Committee sooner than scheduled, for review or consultation. In emergent circumstances, which place individuals at imminent risk of serious harm, the Behavior Treatment Committee Chairperson can determine to supersede the usual process and implement Behavioral Treatment interventions independent of the committee. The Behavior Treatment Plan would still need presentation to the committee and appropriate approvals for continuance and periodic review. This practice would be the rare exception, not the norm. Berrien Mental Health Authority (BMHA) will not

utilize the practice of aversive techniques to manage consumer behaviors. The committee will arrange for an evaluation of the BTC's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates.

DEFINITIONS:

A. Anatomical Support: 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.

B. Aversive Techniques: Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include, electric shock, foul odors, loud noises, mouthwash, water mist or other use of mouthwash, water mist or other noxious substance to consequate target 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. 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 for the purposes of this technical requirement. *(*BMHA policy prohibits the use of aversive techniques to manage consumer behavior.)*

C. Bodily Function: The usual action of any region or organ of the body.

D. Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

E. Consent: 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.

F. 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. Each agency shall have protocols specifying what physical management techniques are approved for use.

G. Evidence-based Practice: The integration of the best research evidence with clinical expertise and consumer values, or clinical interventions or practices for which there is consistent scientific evidence proving that they repeatedly produce specific, intended results.

H. Functional Behavioral Assessment (FBA): An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of particular behavior and guide the development of an effective 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 of the recipient.

Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.

I. Imminent Risk: An event/action that is about to occur that will likely result in the serious physical harm of one's self or others.

J. Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the recipient to achieve treatment, 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 by the Committee.

K. 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 restraint shall only be used as specified in the IPOS for medical or dental procedures.

L. Person Centered Planning: 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.

M. Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact to prevent the individual from harming himself, herself, or others. Note: 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. Use of physical management to restrict movement, as defined here, requires the review and approval by the Committee. To ensure the safety of each consumer and staff, each agency shall designate the emergency physical management techniques to be utilized during emergency situations.

N. 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 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.

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

P. Prone Immobilization: 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.**

Q. 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 the subdivision and incorporated in the written IPOS shall not be considered a restraint as defined below.

R. Psychotropic Drug: Any medication administered for the treatment or amelioration of disorders of thought, mood or behavior.

S. Request for Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting 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 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 techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

T. Restraint: *Restraint is **prohibited** except in a state-operated facility or a licensed hospital. Any physical or mechanical device, material or equipment that immobilizes or reduces the ability of the recipient to move his or her arms, legs, body or head freely is considered restraint. Restraint does not include the use of a device primarily intended to provide anatomical support.

U. Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as 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.

V. Seclusion: The temporary placement of a recipient 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.

W. Serious Physical Harm: Physical damage suffered by a recipient that a physician or registered nurse determines caused or could have cause the death of a recipient, cause the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

X. 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.

Y. Support Plan: A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

Z. Therapeutic De-escalation: An intervention, the implementation of which is incorporated in the individualized 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.

AA. Time Out: 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.

BB. Treatment Plan: 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.

CC. Unreasonable Force: 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:

a. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
b. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
c. The physical management used is not in compliance with the emergency interventions authorized in the recipient's IPOS.
d. 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.

PROCEDURE:

I. COMMITTEE STRUCTURE/APPOINTMENT TENURE AND VOTING

The committee shall be comprised at least three individuals:

1. One of whom shall be a board-certified behavior analyst and/or licensed psychologist as defined in Section 2.4, Staff Provider Qualification in the Medicaid Provider Manual, with the specified training;
2. At least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 220.110c (10).
3. 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.
4. 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 Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Member may be re-appointed to consecutive terms.

D. A quorum of the committee shall be three voting members. At no time should the appointments to the committee not include the *required* voting and non-voting members (1.–3. above) or have less membership than a quorum of *voting* members (3).

E. Only committee members appointed by the CEO shall have voting privileges. Other people shall be asked to attend and participate for professional and educational purposes but would not have voting privileges.

F. Approval of individual behavior programs for consumer shall be by all of the committee members present, given that there is a quorum.

G. The committee shall meet at a frequency to fulfill responsibilities, but no less than monthly.

H. Individual committee members will abstain from decision making with respect to programs prepared by them or for which they individually have direct responsibility as part of the treatment.

II. COMMITTEE FUNCTIONS

A. The functions of the Behavior Treatment Committee (BTC) shall be as follows:

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 plan proposing to utilize intrusive or restrictive techniques (see definitions).
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 him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitation 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 Individual Plan of Services (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]).
7. On quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as,
    a) Dates and numbers of the interventions used.
    b) The settings where behaviors and interventions occurred.
    c) Observations about any events, setting, 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) Review and modification or development, if needed, of the individual's behavior plan

j) Staff development and training and supervisory guidance to reduce the use of these interventions.

8. The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDHHS review. Physical management, permitted for intervention in emergencies only, is considered a critical incident that must be managed and reported according to the QAPIP standards as risk event. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.
9. In addition, the Committee may:
    a) Advise and recommend to the agency the need for specific staff or home specific training in positive behavioral supports and strength based models, and other individual-specific non-violent interventions.
    b) Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or other at risk or harm.
    c) 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.
    d) Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
    e) Provide specific case consultation as requested by professional staff of the agency.
    f) Assist in assuring that other related standards are met, e.g., positive behavior supports.
    g) Serve another service entity, e.g., affiliate or subcontractor, if agreeable between the involved parties.

III. Behavior Treatment Plan Standards

A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the target behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual, or his/her guardian on his/her guardian on his/her behalf if one has 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.

C. 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 Committee. Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than 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 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 others, approved emergency interventions may be implemented.

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

E. Plans and supporting documentation that are forwarded to the Committee for review shall be accompanied by and submitted a minimum of 3 business days prior to the scheduled meeting with the following components:

   a. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   b. A functional behavioral assessment.
   c. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
   d. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
   e. Evidence of continued efforts to find other options.
   f. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   g. 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 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).

F. Plans and documentation submitted after deadline may have their scheduled review delayed until the next meeting.

IV. COMMITTEE REVIEW PROCESS

A. Regular program seeking approval from BTC shall follow these steps:

   1. The person requesting BTC review shall arrange with the BTC chairperson to meet at a mutually agreeable date and time.
   2. The responsible person or designee must be present at the times the BTC reviews the program. At his or her discretion, the responsible person presenting the program can invite others to attend that BTC meeting when the consumer program is being discussed.
   3. The initial proposal shall contain a plan to reduce the restrictive or intrusive component of the BTP, whenever possible, predicted on the predetermined

criteria reflecting success of the BTP. All plans shall be developed with the expectation of an environment built around Positive Behavior Supports. Those programs trained in Gentle Teaching techniques shall receive annual training to reinforce those philosophies and maintain those practices.

4. Behavior Treatment Plans will be reviewed by the Behavior Treatment Committee and the documentation of this review will be contained in the consumer's chart in a billable service note as well as in the Behavior Treatment Plans section of the chart. Documentation of this plan review and the committee's action will further be contained in the Riverwood Center BTC meeting minutes for that date. Once signatures by the consumer and/or guardian are obtained, an in-service with the residential staff will be scheduled.
5. When a BTP has been approved, it shall be reviewed every 90 days, or reviewed at a frequency specified by the Behavior Treatment Committee according to the nature and severity of the behaviors being targeted. The Behavior Treatment Plan is considered an extension of the Individual Plan of Service (IPOS) and the frequency of its reviews will be documented in the IPOS as well.

B. Expedited Review of Proposed Behavior Treatment Plans (BTPs):

1. Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.
2. The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of the following AFC Licensing Rule:
    a) Adult Foster Care Licensing R 400.14309 Crisis intervention (1) 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 crisis 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. (Emphasis added)**
    b) Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, Behavior Analyst, Behavior Specialist, RN, Case Manager), the plan requires immediate implementation.
        (1) The professional staff requesting an expedited review will complete the "Expedited BTP Review" Form and submit to the BTC Chair as soon as possible. Requests will be addressed as soon as possible, but not to exceed 2 business days from date of submission.
    c) The BTC Chair and/or BTC Co-Chair may receive, review and approve such plans on behalf of the Committee. In addition, a representative from the Recipient Rights Office must be informed of the proposed plan to

assure that any potential rights issues are addressed prior to implementation of the plan.

d) Upon approval, the plan may be trained and implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee. In addition, a full in-person training and in-servicing of the revised plan will occur no more than 7 business days from the date of expedited approval.

V. RESPONSIBILITIES

CEO of the Berrien Mental Health Authority Board: To review, approve and distribute all procedures relating to the BTC and to respond in writing to requests for exceptions to these procedures. To appoint all BTC members which have been submitted to BTC and render a final decision. To approve appropriate annual training requests for BTC members.

DIVISION/PROGRAM/UNIT SUPERVISOR: To understand, educate, train and survey staff on all BTC procedures.

STAFF: To understand BTC procedures, implement programs as written, request training if needed and to provide feedback to supervision when procedures may need modification. To assure the following standards from the Mental Health Code and BMHA procedures are included: Individual restrictions deemed clinically necessary must be documented in the individual's plan of service (IPOS), including: justification for its adoption, time limits for the date the restriction(s) will be reviewed and/or expires. Documentation must also be included that describes attempts that have been made to avoid such restrictions as well as what actions will be taken as part of the plan to ameliorate or eliminate the need for such restrictions in the future. A recipient or guardian may appeal restrictions substantial in scope and duration to the person in charge of implementing the plan of service. This review shall be completed as soon as possible, but no longer than 30 days from the date of the request, as provided in Section 712(2) of the Mental Health Code.

BTC: To adhere to all internal and externally defined standards. Review and approve all programs for consumers of Berrien Mental Health Authority that involve the use of intrusive or restrictive techniques. The data required for submission to MDHHS will be captured on the revised behavior data sheets. The committee will do a quality review on each new or revised plan. A summary report will be submitted quarterly to the Continuous Quality Improvement Evaluation Committee.

Legal References:

1997 federal Balanced Budget Act at 42 CFR 438.100
MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY 18
Attachment C6.8.3.111
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
Department of Health and Human Services Administrative Rule 330.7199(2)(g)

FORMS:

Behavior Treatment Review/Minutes
Behavior Treatment Quality Review
Behavior Treatment Quality Review Quarterly Report
ABC Chart
Behavior Data Forms
BTC Committee Appointments

Reviewer: Behavior Treatment Committee & Office of Recipient Rights
Reviewed: 5/07, 2/08, 9/11, 9/12, 7/13, 5/14, 7/15, 4/16, 2/17, 3/18, 6/18, 2/19, 7/19, 4/2020, 10/2020, 1/2021, 8/2021, 8/2022, 5/2023, 8/2023, 2/2024, 8/2025, 7/2026

BEHAVIOR TREATMENT COMMITTEE **FY 2027**
APPOINTMENTS

		Term Ends
Kari Carrington, MA, BCBA, LBA	Chair	2027
Joseph Hayes, M.Ed, BCBA, LBA	Co-Chair (PRN)	2027
Semy Mangena, MA, BCBA, LBA	Co-Chair (PRN)	2027
Lucian Tamer, MD	Physician/Psychiatrist	2027
Andrew Mahler	Person Centered Planning	2027
Michelle Tahaney, MA, LLP	Person Centered Planning	2027
Joyce Divis	Community Advocate	2027
Michelle Charles	Community Advocate	2027
Anne Simpson	Office of Recipient Rights	by position
Natasha Stewart	Office of Recipient Rights	by position

In accordance with Procedure 01-03-02 the committee shall be comprised of the following individuals:

1. At least one of the members (can be more) is required to be a licensed physician/psychiatrist. (Behavior analysis training is not specifically required.)
    - Lucien Tamer, MD

2. At least one of the members (can be more) is required to be a full or limited licensed psychologist with at least one year experience and formal training in applied behavioral analysis at the graduate level at an accredited college/university which included theory, application and practicum.
    - Kari Carrington, MA, BCBA, LBA
    - Joseph Hayes, M.Ed, BCBA, LBA
    - Semy Mangena, MA, BCBA, LBA

3. An individual from the Office of Recipient rights in a non-voting advisory capacity.
    - Anne Simpson
    - Natasha Stewart

4. An individual who is skilled in person centered planning and direct experience with the public mental health system.
    - Andrew Mahler
    - Michelle Tahaney, MA, LLP

5. Community/Consumer Advocate
    - Joyce Divis
    - Michelle Charles