TO BE RESCINDED

5122-2-19 **Integrated behavioral healthcare system (IBHS) behavior therapy rule for intensive and specialized services and forensic inpatient services.**

(A) The purpose of this rule shall be to facilitate the development of appropriate behavior therapy interventions in the intensive and specialized services (ISS) and forensic inpatient services of the Ohio department of mental health (ODMH) and to protect the rights of clients involved in behavior therapy.

(B) The provisions of this rule shall be applicable to all behavioral healthcare organizations (BHOs) under the managing responsibility of ODMH.

(C) It is the intent of this rule to promote quality behavioral strategies and interventions that promote the recovery of the individual.

(D) Behavior therapy and recovery: key principles within the recovery model relate to consumer self-determination and collaboration with clinicians in the creation of plans for recovery. With these principles in mind, the appropriate development of behavioral contracts with consumers is strongly encouraged. Participation of a client in a behavior therapy plan shall be voluntary. The consent may be withdrawn at any time. The client shall be involved in the development of the plan to the greatest extent possible. These contracts should involve a negotiated process within which the consumer has maximum input into the important contractual elements. Consumers should be advised, as part of the informed consent process, that their plan may be reviewed by either a BHO or department committee. These elements include the goals and specific behavioral objectives to be pursued, targeted behaviors, time frames involved, and interventions to be used, the latter including, but not limited to, positive reinforcers and differential reinforcers. The planning process should include not only the consent but, to the greatest extent possible, the active input and participation of the consumer in the process of personal decision making.

In general, the design of behavioral plans should be such that choices on the part of the consumer are encouraged. Behavioral plans should be designed to include realistic and attainable behavioral objectives that the consumer can actually meet. Behavioral plans should include the regular opportunity for social reinforcement. Fading out of specialized behavioral interventions and supports should be an integral part of planning. Specialized interventions should be short term in nature, but matched to the current needs and recovery level of the consumer. The educational needs of the consumer and key others, such as family members and peers/friends, should be addressed. Behavioral planning should include the education and training of significant others in the behavioral strategies being employed.

All consumers are considered to be in the process of recovery. The department of mental health is committed to making available the full range of services that will enable consumers to recognize and manage those problems that may inhibit recovery, develop new skills, build on strengths, support and develop relationships, and grow as human beings. One important area of services is behavioral interventions. We make available services that represent best practices in learning new behaviors, developing new skills, strengthening and improving existing skills, changing behaviors and cognitions that are causing problems, and developing improved self-management skills. These therapies include: relaxation therapy, cognitive behavior therapy, social and coping skills training, anger management, dialectical behavior therapy, self-instructional training, self-control monitoring, systematic desensitization, assertiveness training, generalization and maintenance procedures, and bio-feedback.

Many behavior therapies may be very useful to consumers in their recovery and it is also the purpose of this rule to support these services at the highest level of quality.

(E) The following definitions shall apply to this rule in addition to or in place of those appearing in rule 5122-1-01 of the Administrative Code:

(1) "Approved behavior therapy plan" means a plan to address specific behavior(s) using behavior therapy that has been reviewed and approved for use by the BHO's behavior therapy committee and, if indicated by this rule on behavior therapy, the department's behavior therapy committee (DBTC).

(2) "Aversive behavior therapy intervention" means any behavior therapy intervention which employs any unpleasant or aversive stimuli and is expected to decrease the target behavior. There may be interventions for health or safety reasons that are aversive but not necessarily behavior therapy interventions. For example, temporarily taking away a client's night stand as a response to a crisis to protect self or others may be aversive but is not behavior therapy. An aversive behavior therapy intervention can be used only if approved by the BHO behavior therapy committee (BHOBTC) and/or department behavior therapy committee (DBTC).

(3) "Aversive stimulus" means an unpleasant, intrusive, or painful stimulus that is expected to decrease a behavior when it is presented immediately and consistently as a consequence of (contingent upon) behavior. In addition, an aversive stimulus may also mean one which the individual will actively work to avoid and its contingent removal is expected to result in an increase in the target behavior. Depending upon the degree of unpleasantness and intrusiveness of the particular aversive stimulus, it will be classified as either a major or minor aversive intervention.

(4) "Behavior therapy" means the application of principles derived from research in experimental and social psychology for the alleviation of human suffering and the enhancement of human functioning. Behavior therapy is a diverse and complex field with many approaches that fall under the aegis of behavior therapy. Behavior therapy is interventions in which positive reinforcers or aversive stimuli are applied in a systematic and contingent manner in the context of individual treatment plans or group programs to change behavior. Behavior therapy emphasizes a systematic evaluation of the effectiveness of these applications. Behavior therapy involves environmental change and social interaction rather than the direct alteration of bodily processes by biological procedures. The aim is primarily educational. The techniques facilitate improved self-control. In the conduct of behavior therapy, a contractual agreement is usually negotiated in which mutually agreeable goals and procedures are specified. Responsible practitioners using behavioral approaches are guided by generally accepted ethical principles.

(5) "BHO behavior therapy committee (BHOBTC)" means the committee(s) appointed by the chief executive officer of each hospital to fulfill the requirements of this rule. The BHOBTC shall have a client advocate in membership.

(6) "Clear treatment reasons" means that permitting the client to exercise a right will present a substantial risk of physical harm to the client or others or will substantially preclude effective treatment of the client. If a right is restricted for clear treatment reasons, the client's written treatment plan shall specify the treatment designed to eliminate the restriction on exercising that right at the earliest possible time.

(7) "Department" means the Ohio department of mental health (ODMH).

(8) "Department behavior therapy committee (DBTC)" means a committee appointed by the medical director of the department of mental health to implement the provisions of this rule.

(9) "Director" means the director of the Ohio department of mental health.

(10) "Extinction" means the discontinuance of a reinforcer that has been maintaining a behavior (for example, when it is observed that an inappropriate behavior is maintained by staff attention, the plan may specify that staff shall not attend to that behavior). Extinction is not an aversive intervention.

(11) "Informed consent" means the voluntary, knowing, intelligent choice of a person, or a person and his/her guardian.

(12) "Noxious substances" means those substances whose primary purpose would be to produce unpleasant effects as part of an approved behavior therapy plan.

(13) "Over-correction" means to correct the environmental effects of an inappropriate act by requiring the client to restore the environment to a state vastly improved over that which existed before the inappropriate act was emitted.

(14) "Positive practice" means to request the client to practice intensively correct forms of relevant behavior to suppress an inappropriate behavior which has been emitted.

(15) "Positive reinforcer" means any event or stimulus which when presented contingent upon a behavior increases the frequency of the occurrence of that behavior.

(16) "Quiet time" means a voluntary procedure through which a client removes him/herself from a situation which is too stimulating in an effort to regain self-control. Quiet time may be initiated by a staff person requesting that a client use this procedure or may be initiated or prompted by the client. A quiet room (unlocked) is a place where quiet time may take place. A quiet room is a place that can be made available at the client's request. The use of quiet time may be part of the treatment plan and documented in the client's medical record. If used in a behavior therapy plan quiet time would be considered a positive intervention. A seclusion room shall not used for quiet time unless specifically approved, in writing, by that BHO's BHOBTC chairperson.

(17) "Ready behavior" means the behavior which the client needs to demonstrate to signal that timeout can be terminated. Ready behavior shall be defined (described) precisely in the behavior plan for each client so that all staff members reinforce the same behavior. Ready behavior shall be explained to the client. Ready behavior shall include a specific description and length of time. Ready behavior should be displayed for as short a time as possible but not to exceed five minutes.

(18) "Recovery" means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.

(19) "Target(ed) behavior" means the behavior which is addressed in the approved behavior therapy plan as the behavior needing changing/enhancing. The behavior should be observable/measurable and so stated in the plan.

(20) "Timeout" means a behavior therapy intervention in which positive reinforcement is not available for a specified period of time or until ready behavior occurs. This intervention shall be part of an approved behavior therapy plan that is documented in the client's medical record. A timeout room is an unlocked room where such an intervention may take place. Timeout does not have to occur in a timeout room, but may occur in an unlocked place which has been previously negotiated in the behavior therapy plan. A seclusion room shall not used for timeout unless specifically approved, in writing, by that BHO's BHOBTC chairperson.

(F) Behavior therapy committees

(1) The DBTC is hereby created and shall consist of a minimum of seven members. All members shall be appointed by the medical director of the department. The director (or designee) of the Ohio legal rights service OLRS shall be an ex-officio member of the DBTC. The functions of the DBTC are:

(a) To work to ensure the availability of quality behavior therapy services in BHO's;

(b) To inform and consult with the director regarding recent developments in behavioral techniques;

(c) To review, approve, and monitor all behavior therapy plans involving the use of major aversive stimuli in individual treatment plans or, in the context of larger plans, to routinely review all minor aversive behavior plans. Plans submitted to the DBTC should not identify the consumer. As part of the plan development process, consumers should be advised that their plans may be reviewed by a committee;

(d) To notify the OLRS as soon as possible that a proposed major aversive plan has been submitted to the DBTC;

(e) To provide assistance to BHOBTCs in carrying out their responsibilities as delineated in this rule; and

(f) To ensure compliance with the provisions of this rule.

(2) The chief executive officer of each BHO, with input from the chief clinical officer, shall establish a BHOBTC by either appointing a committee which functions solely to carry out the requirements stated herein, or designating another BHO committee, also to be referred to as the BHOBTC, to carry out the stated requirements stated herein as one of its functions.

(a) At least one person with behavior therapy expertise shall be a member of the BHOBTC. It is recommended that an ex-client and a family member of a client or ex-client be appointed to the BHOBTC, and that the appointment(s) be known to any client whose care is being discussed. The functions of the BHOBTC are:

(i) To identify, review, and monitor for effectiveness all behavior therapy plans at that BHO. Plans submitted for review shall not identify the consumer. Positive intervention plans may be implemented by the treatment team without prior approval, but shall be immediately reported to the BHOBTC for review. Minor aversive intervention plans shall be approved by the BHOBTC before implementation. Major aversive intervention plans shall require recommendation by the BHOBTC, and shall be referred to the DBTC for approval before implementation;

(ii) To provide consultation to the clinical staff; to be aware of and disseminate the latest developments in the behavior therapy field;

(iii) To provide in-service training on behavior therapy techniques to BHO staff;

(iv) To facilitate the development of appropriate behavioral plans;

(v) To provide the DBTC with copies of the minutes of meetings;

(vi) To provide the DBTC with monthly reports on all behavioral plans using minor and/or major aversive interventions; and

(vii) To provide the DBTC with a yearly updated BHOBTC membership list.

(G) Behavior therapies

The ODMH encourages consumer involvement and consumer advice and supports

hope by plans designed to succeed by encouraging self-reliance and independence. The ODMH is committed to ensuring that effective therapies are made available to clients who receive services and that these services reflect recent developments in effective behavior therapy techniques and are integrated within existing mental health services. Behavior therapy can increase clients' choices and skills applicable in their own lives. The ODMH promotes and encourages behavior therapy and not behavior control. Behavior therapy focuses on changing behaviors for the benefit of the client. Behavior therapy cannot be used to curtail or circumvent clients' rights but only to increase their ability to exercise their rights. Behavior therapies encouraged for use include, but are not limited to, cognitive behavior therapy, dialectical behavior therapy, skills training, desensitization, and procedures based on reinforcement theory.

(H) Behavior therapy plans

(1) Positive interventions

(a) Positive interventions include, but are not limited to, the following non-restrictive procedures:

(i) Positive reinforcement;

(ii) Differential reinforcement of incompatible behaviors;

(iii) Differential reinforcement of other behaviors;

(iv) Shaping and chaining; and

(v) Prompting and fading.

(b) Behavior therapy plans involving positive interventions are encouraged and may be initiated by the treatment team when the following procedures have been met:

(i) The intervention is part of the written treatment plan;

(ii) Provisions for the training of staff in the proper use of the intervention have been developed. Documentation of the training shall be available to the BHOBTC; and

(iii) The BHOBTC has been notified that a plan has been initiated.

(c) Informed consent for participation in an extinction plan is not required. The client should be involved to the maximum extent possible in the development of the plan.

(2) Minor aversive interventions

(a) Minor aversive interventions include, but are not limited to, use of the following mildly and moderately unpleasant or intrusive aversive stimuli or procedures:

(i) Timeouts of thirty minutes or less including ready behavior. The need for observation during timeout shall be determined and addressed in the behavior therapy plan.

(ii) Loss of tokens;

(iii) Over-correction and positive practice of thirty (30) minutes or less;

(iv) The time-limited contingent removal of items that are reinforcing to the client that are not listed as major aversives; and

(v) The time-limited contingent loss of access to the client's own room.

(b) Behavior therapy plans involving minor aversive interventions may only be initiated when the following conditions and procedures have been met:

(i) There is documentation of systematic positive interventions that have been attempted and failed and data on the results of these attempts; or documentation from behavior therapy literature that positive interventions are not effective for reducing the target behavior;

(ii) The treatment team shall have submitted a written proposal to the BHOBTC. The proposal shall include baseline (pre-intervention) behavior, if appropriate, data collection procedures for the aversive intervention and the time frames for the evaluation of effectiveness of the plan.

(iii) The BHOBTC shall have reviewed and approved both the proposal

and the behavior therapy coordinator;

(iv) If approved, before implementation, staff shall receive training on the plan. This training shall be documented and reported to the BHOBTC;

(v) Substitute target behavior to be increased shall be identified and plan developed for their acquisition; and

(vi) Written informed consent of client and guardian (if any).

(c) The BHOBTC shall monitor the use of minor aversive interventions involved in behavior therapy plans. They shall maintain monthly reports that are submitted to the DBTC that include data on target behaviors and utilization of aversive interventions.

(3) Major aversive interventions

(a) Major aversive interventions may be initiated only if positive interventions and minor aversive interventions have been attempted and found ineffective. Major aversive interventions shall not be used unless a client continues to engage in behavior dangerous to self or others after other forms of treatment have been attempted. There is no presumption based upon urgency or a client's dangerousness that major aversive interventions are the intervention of choice. In addition, major aversive interventions may be initiated only when the following conditions and procedures have been met:

(i) The treatment team staff shall have submitted a written proposal through the BHOBTC to the DBTC which shall include, but not be limited to, the following information:

(a) Client to be served (identified by client number only);

(b) General description of the client to be served;

(c) Target behavior described in observable, measurable terms. This behavior must be one which is destructive to self or others;

(d) Baseline (pre-intervention) data on target behavior;

(e) Documentation of systematic positive interventions attempted and data on the results of these attempts or documentation from behavior therapy literature that positive interventions are not effective for reducing the target behavior;

(f) Documentation of systematic minor aversive interventions recently attempted and data on their results;

(g) Detailed description of the aversive intervention;

(h) Substitute target behavior to be increased and plan for its acquisition;

(i) Data collection procedures on the target behavior, on the use of the aversive intervention and time frames for the evaluation for effectiveness of the behavior plan;

(j) Designation of staff involved shall include the name and qualifications of the behavior therapy coordinator as well as indication of how staff are, or will, be trained in the proper use of the intervention;

(k) Documentation of the opportunity of client and/or guardian input;

(l) Written statement by the attending physician indicating any medical or psychiatric contraindications and whether the major aversive intervention is medically advisable. This statement should include a description of any physical disorders which could impact on the planned intervention;

(m) Written informed consent of client and guardian (if any); and

(n) Letter from the BHOBTC and chief executive officer and chief clinical officer of the BHO indicating that they had reviewed data documenting the unsuccessful utilization of positive and minor aversive interventions and that they have recommended the use of the major aversive intervention.

(ii) The DBTC shall have reviewed the proposal and granted approval for the use of the proposed intervention to the BHOBTC.

(b) Major aversive interventions include, but are not limited to, use of the following severely unpleasant or intrusive aversive stimuli or procedures to change behaviors (this list has not been placed in a hierarchical order with respect to aversiveness):

(i) The contingent application of noxious substances;

(ii) The contingent withholding or loss of nicotine or caffeine;

(iii) The contingent substitution for, or delay of the regular meal (substituted meal content to be approved by dietitian). The delay of a meal shall not be longer than three hours with the time delay documented in the behavior therapy plan. Meals cannot be totally withheld as a behavioral intervention;

(iv) The contingent loss of bed (mattress must be provided at regularly scheduled hours of sleep);

(v) The contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, loud or annoying noises;

(c) For monitoring purposes, the BHOBTC shall submit to the DBTC monthly progress reports, (or, more frequently if requested by the DBTC). Individual consumers shall not be identifiable in these reports.

(d) The contingent use of electric shock as part of a behavioral plan is prohibited.

(4) No client's rights shall be restricted in a behavior therapy plan except as permitted in divisions (D), (F) and (I) of section 5122.29 of the Revised Code, unless for clear treatment reasons documented in the client's medical record and unless the target behavior involves the abuse of the right. If any right is restricted or withheld as a behavioral intervention the behavioral plan shall:

(a) Be directed towards reinstatement of that right at the earliest possible time;

(b) Be reported to the BHOBTC and DBTC;

(c) Describe how the client(s) will regain the right;

(d) Describe how the plan will be monitored and the frequency of review;

(e) Be communicated to the client;

(f) Document that the client has been informed that the plan restricts a legal right as defined in divisions (D), (F), and (I) of section 5122.29 of the Revised Code;

(g) In no case can the client's right to contact the client advocate, OLRS, or guardian be restricted; and

(h) Include written informed consent of the client and his/her guardian, if any, to the restriction of a right.

(I) Recommendations

Behavior therapy recommendations may be prepared by the DBTC and disseminated as appropriate.

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CERTIFIED ELECTRONICALLY

Certification

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