

## **POLICY 1300**

### **BEHAVIORAL HEALTH SERVICES**

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## **1300 Behavioral Health Services**

### **1300.01 Purpose**

The purpose of this policy is to direct the Clermont County Board of Developmental Disabilities (CCBDD) in the provision of behavioral health services. These services include those provided through the specialization of Behavior Support, and the Mental Health Supports and Services program.

This policy limits the use of and sets forth requirements for the development and implementation of behavioral support strategies that include restrictive measures for the purpose of ensuring that:

- 1 Individuals with developmental disabilities are supported in a caring and responsive manner that promotes dignity, respect, and trust and with recognition that they are equal citizens with the same rights and personal freedoms granted to Ohioans without developmental disabilities;
- 2 An individual's services and supports are based on an understanding of the individual and the reasons for the individual's actions;
- 3 Effort is directed at creating opportunities for individuals to exercise choice in matters affecting their everyday lives and supporting individuals to make choices that yield positive outcomes; and
- 4 Restrictive measures are used only when necessary to keep people safe and always in conjunction with positive measures.

### **1300.02 Definitions and Rule Reference**

For the purpose of providing behavior support services, the CCBDD will follow definitions and rule that are established in Ohio Administrative Code, Chapter 5123, Department of Developmental Disabilities.

These codes clearly articulate **what is** and **is not** allowed when working with individuals and should be reviewed and understood by all department staff.

Individuals receiving services in a setting governed by the Ohio Department of Education shall be supported in accordance with rule 3301-35-15 of the Administrative Code.

CCBDD policy furthers rule found in Chapter 5123-2-06 by adding that a manual restraint shall be applied no longer than necessary to mitigate risk of harm and **no more than 5 consecutive minutes**.

For the purpose of providing mental health services, the CCBDD will follow definitions and rule that are established in Ohio Administrative Code, specifically Chapter 5122, Department of Mental and Addiction Services, and Chapter 4757, Counselor, Social

Worker, and Marriage and Family Therapist Board. Department staff are responsible for reviewing, understanding and implementing rule identified in these codes.

### **1300.03 Mission, Vision, and Goals**

The mission of the Behavioral Health Services Department is to provide compassionate, behavioral health services to individuals with developmental disabilities, their families, and their communities, through education, support, mental health treatment, and advocacy.

Our vision is to provide culturally competent, wellness-focused services that promote trauma responsive strategies with an emphasis on building resilience in those we support. We strive to embody the Clermont County Board of Developmental Disabilities Core Values of Safety, Understanding, Responsibility, and Engagement (S.U.R.E).

Our goal for all the individuals we serve is to:

- Support recovery, health and well-being;
- Enhance quality of life;
- Reduce mental health symptoms and build resilience;
- Restore and/or improve day to day functioning; and
- Build support systems and the ability to participate in community activities

### **1300.04 Description of Services**

CCBDD provides the following services/activities through the Behavioral Health Services Department:

- Behavior Support, including comprehensive behavioral assessments, development of strategies, and training;
- Mental Health general services as defined by the Ohio Department of Mental Health and Addiction Services (OMHAS), which include: assessment, counseling and therapy.
- Community Psychiatric Supportive Treatment (CPST)
- Therapeutic Behavioral Services and Psychosocial Rehabilitation

### **1300.05 Annual Performance Improvement Plan**

The Behavioral Health Services department is committed to establishing a planned, systematic, department-wide approach to performance improvement that is both collaborative and interdisciplinary. We will measure the performance processes which

support care and establish a method of data collection and analysis in order to identify areas of needed improvement and develop and implement improvement plans which support achieving performance targets, client satisfaction, and positive client outcomes.

At a minimum, performance improvement methodologies will include:

- Business operations;
- Client satisfaction;
- Stakeholder satisfaction;
- Client outcomes;
- The quality of service delivery, including appropriateness, and efficiency; and
- Client protections, including seclusion and restraint, if applicable, clients' rights, complaints and grievances, and incident notification.

The BHS department will develop an annual performance improvement plan which articulates:

- the data to be collected in the coming year, method of analysis, and frequency of collection and analysis;
- identified areas of needed improvement;
- an action plan to address those areas;
- how that plan will be implemented, monitored, and evaluated;
- the activities that will evaluate the effectiveness of the overall improvement process

### **1300.06 Behavioral Support**

**Behavioral support strategies** are strategies included in person-centered plans that help enhance individuals' lives by reducing risk of harm to themselves or to others.

#### **A. Development of a behavioral support strategy that includes restrictive measures.**

1. The focus of a behavioral support strategy is the proactive creation of supportive environments that enhance an individual's quality of life by understanding and respecting the individual's needs and expanding opportunities for the individual to communicate and exercise choice and control through identification and implementation of positive measures such as:
  - (a) Emphasizing alternative ways for the individual to communicate needs and to have needs met;
  - (b) Adjusting the physical or social environment;

- (c) Addressing sensory stimuli;
  - (d) Adjusting schedules; and
  - (e) Establishing trusting relationships.
2. A behavioral support strategy that includes restrictive measures requires:
- (a) Documentation that demonstrates that positive measures have been employed and have been determined ineffective.
  - (b) An assessment conducted within the past twelve months that clearly describes:
    - (i) The behavior that poses risk of harm or likelihood of legal sanction or the individual's engagement in a precisely-defined pattern of behavior that is very likely to result in risk of harm;
    - (ii) The level of harm or type of legal sanction that could reasonably be expected to occur with the behavior;
    - (iii) When the behavior is likely to occur;
    - (iv) The individual's interpersonal, environmental, medical, mental health, communication, sensory, and emotional needs; diagnosis; and life history including traumatic experiences as a means to gain insight into origins and patterns of the individual's actions; and
    - (v) The nature and degree of risk to the individual if the restrictive measure is implemented.
  - (c) A description of actions to be taken to:
    - (i) Mitigate risk of harm or likelihood of legal sanction;
    - (ii) Reduce and ultimately eliminate the need for restrictive measures; and
    - (iii) Ensure environments where the individual has access to preferred activities and is less likely to engage in unsafe actions due to boredom, frustration, lack of effective communication, or unrecognized health problems.
3. A behavioral support strategy shall never include prohibited measures.
4. Age-related developmental stages are considered when assessing whether a strategy is to be considered restrictive.
5. Persons who conduct assessments and develop behavioral support strategies that include restrictive measures shall:
- (a) Hold a valid license issued by the Ohio board of psychology;
  - (b) Hold a valid license issued by the Ohio counselor, social worker and marriage and family therapist board;

- (c) Hold a valid physician license issued by the state medical board of Ohio; or
  - (d) Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.
6. A behavioral support strategy that includes restrictive measures shall:
- (a) Be designed in a manner that promotes healing, recovery, and resilience;
  - (b) Have the goal of helping the individual to achieve outcomes and pursue interests while reducing or eliminating the need for restrictive measures to ensure safety;
  - (c) Describe tangible outcomes and goals and how progress toward achievement of outcomes and goals will be identified;
  - (d) Recognize the role environment has on behavior;
  - (e) Capitalize on the individual's strengths to meet challenges and needs;
  - (f) Delineate restrictive measures to be implemented and identify those who are responsible for implementation;
  - (g) Specify steps to be taken to ensure the safety of the individual and others;
  - (h) As applicable, identify needed services and supports to assist the individual in meeting court-ordered community controls such as mandated sex offender registration, drug-testing, or participation in mental health treatment; and
  - (i) As applicable, outline necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the individual's care, confinement, or reentry to the community.
7. A behavioral support strategy that includes chemical restraint, manual restraint, or time-out will specify when and how the provider will notify the individual's guardian when such restraint is used.
8. When a behavioral support strategy that includes restrictive measures is proposed by an individual and the individual's team, the qualified intellectual disability professional or the service and support administrator, as applicable, shall:
- (a) Ensure the strategy is developed in accordance with the principles of person-centered planning and trauma-informed care and incorporated as an integral part of the individual service plan.
  - (b) When indicated, seek input from persons with specialized expertise to address an individual's specific support needs.

- (c) Secure informed consent of the individual or the individual's guardian, as applicable.
- (d) Submit to the human rights committee the strategy and documentation, including the record of restrictive measures, based upon an assessment that clearly indicates:
  - (i) The justification for the proposed restrictive measure, that is:
    - a. When manual restraint, mechanical restraint, or time-out is proposed -- risk of harm;
    - b. When chemical restraint is proposed -- risk of harm or how the individual's engagement in a precisely-defined pattern of behavior is very likely to result in risk of harm; or
    - c. When rights restriction is proposed -- risk of harm or how the individual's actions are very likely to result in the individual being the subject of a legal sanction.
  - (ii) The nature and degree of risk to the individual if the restrictive measure is implemented.
- (e) Ensure the strategy is reviewed and approved in accordance with these policies prior to implementation and whenever the behavioral support strategy is revised to add restrictive measures.
- (f) Ensure the strategy is reviewed by the individual and the individual's team at least every ninety calendar days or more frequently when specified by the human rights committee to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised.
  - (i) The review shall consider:
    - (a) Numeric data on changes in the severity or frequency of behaviors that had been targeted for reduction due to a threat to safety or wellbeing;
    - (b) New skills that have been developed which have reduced or eliminated threats to safety or wellbeing;
    - (c) The individual's self-report of overall satisfaction in achieving desired outcomes and pursuing interests; and
    - (d) Observations by paid staff and/or natural supports as they relate to safety or wellbeing and the individual's achievement of desired outcomes and pursuit of interests.

- (ii) When a manual restraint has been used in the past ninety calendar days, the review shall include seeking the perspective of the individual and at least one direct support professional involved in use of the manual restraint regarding the reason the manual restraint occurred and what could be done differently in the future to avoid manual restraint.
- (iii) A decision to continue the strategy shall be based upon review of up-to-date information justifying the continuation of the strategy.

### **Reconsideration of a medication initially presumed to not be a chemical restraint**

1. When administration of a medication initially presumed to not be a chemical restraint per definition articulated above, actually results in a general or non-specific blunt suppression of behavior, the provider is to alert the individual's qualified intellectual disability professional or service and support administrator, as applicable. The qualified intellectual disability professional or the service and support administrator is to ensure the prescriber of the medication and the individual's team are notified.
  - (a) The prescriber of the medication may adjust the medication (type or dose) in an effort to abate the general or non-specific blunt suppression of behavior.
  - (b) When the prescriber of the medication is not inclined to adjust the medication, the individual's team is to meet to consider what actions may be necessary (e.g., seeking an opinion from a different prescriber or introducing activities that may mitigate the impact of the medication on the individual's ability to complete activities of daily living).
2. When a medication (as originally administered or as adjusted) continues to cause a general or non-specific blunt suppression of behavior beyond thirty calendar days, the medication is to be regarded as a chemical restraint and submitted to the human rights committee as outlined by this policy.

### **Implementation of behavioral support strategies with restrictive measures**

1. Restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare, and rights of individuals receiving specialized services.
2. Each person providing specialized services to an individual with a behavioral support strategy that includes restrictive measures shall successfully complete training in the strategy prior to serving the individual.

3. After each incidence of manual restraint, a provider shall take any measures necessary to ensure the safety and wellbeing of the individual who was restrained, individuals who witnessed the manual restraint, and staff and minimize traumas for all involved.
4. Each provider shall maintain a record of the date, time, and antecedent factors regarding each event of a restrictive measure other than a restrictive measure that is not based on antecedent factors (e.g., bed alarm or locked cabinet). The record for each event of a manual restraint or a mechanical restraint will include the duration. The provider will share the record with the individual or the individual's guardian, as applicable, and the individual's team whenever the individual's behavioral support strategy is being reviewed or reconsidered.

### **Review of behavioral support strategies that include restrictive measures**

There are two distinct processes for review of behavioral support strategies that include restrictive measures based on the nature of the request:

1. Emergency request.
  - (a) An emergency request for a behavioral support strategy that includes restrictive measures shall consist of:
    - (i) A description of the restrictive measures to be implemented;
    - (ii) Documentation of risk of harm or legal sanction which demonstrates the situation is an emergency;
    - (iii) A description of positive measures that have been implemented and proved ineffective or infeasible;
    - (iv) Any medical contraindications; and
    - (v) Informed consent by the individual or the individual's guardian, as applicable.
  - (b) Prior to implementation of a behavioral support strategy submitted via the emergency request process, the strategy must be approved by:
    - (i) A quorum of members of the human rights committee in accordance with 42 C.F.R. 483.440 as in effect on the effective date of this rule for an individual who resides in an intermediate care facility for individuals with intellectual disabilities; or
    - (ii) The superintendent of the county board or the superintendent's designee for an individual who does not reside in an intermediate care facility for individuals with intellectual disabilities.

- (c) A behavioral support strategy approved via the emergency request process may be in place for a period not to exceed forty-five calendar days. Continuation of the strategy beyond the initial forty-five calendar days requires approval by the human rights committee in accordance with the process for a routine request described in this policy.

## 2. Routine request.

- (a) Absent an emergency, a human rights committee shall review a request to implement a behavioral support strategy that includes restrictive measures.
- (b) An individual or the individual's guardian, as applicable, is to be notified at least seventy-two hours in advance of the date, time, and location of the human rights committee meeting at which the individual's behavioral support strategy will be reviewed. The individual or guardian has the right to attend to present related information in advance of the human rights committee commencing its review.
- (c) In its review of an individual's behavioral support strategy, the human rights committee is to:
  - (i) Ensure that the planning process outlined in this rule has been followed and that the individual or the individual's guardian, as applicable, has provided informed consent.
  - (ii) Ensure that the proposed restrictive measures are necessary to reduce risk of harm or likelihood of legal sanction.
  - (iii) When indicated, seek input from persons with specialized expertise to address an individual's specific support needs.
  - (iv) Ensure that the overall outcome of the behavioral support strategy promotes the physical, emotional, and psychological wellbeing of the individual while reducing risk of harm or likelihood of legal sanction.
  - (v) Ensure that a restrictive measure is temporary in nature and occurs only in specifically defined situations based on:
    - (a) Risk of harm for manual restraint, mechanical restraint, or time-out.
    - (b) Risk of harm or an individual's engagement in a precisely defined pattern of behavior that is very likely to result in risk of harm for chemical restraint; or
    - (c) Risk of harm or likelihood of legal sanction for a rights restriction.
  - (vi) Verify that any behavioral support strategy that includes restrictive measures also incorporates positive measures designed to enable the

individual to feel safe, respected, and valued while emphasizing choice, self-determination, and an improved quality of life.

- (vii) Determine the period of time for which a restrictive measure is appropriate and may approve a strategy that includes restrictive measures for any number of days not to exceed three hundred sixty-five.
  - (viii) Approve in whole or in part, reject in whole or in part, monitor, and when indicated, reauthorize behavioral support strategies that include restrictive measures.
  - (ix) Communicate the committee's determination including an explanation of its rejection of a strategy in writing to the qualified intellectual disability professional or service and support administrator that submitted the request for approval.
- (d) The support administrator shall communicate in writing to the individual or the individual's guardian, as applicable, the determination of the human rights committee including an explanation of rejection of a strategy as well as the individual's or guardian's right to seek reconsideration when the human rights committee rejects a strategy.
- (e) An individual or the individual's guardian, as applicable, may seek reconsideration of rejection by the human rights committee of a strategy that includes restrictive measures by submitting the request for reconsideration with additional information provided as rationale for the request to the support administrator, as applicable, in writing within fourteen calendar days of being informed of the rejection. The support administrator is to forward the request to the human rights committee within seventy-two hours. The human rights committee will consider the request for reconsideration and respond in writing to the individual or guardian within fourteen calendar days of receiving the request.
- (f) An individual who resides in an intermediate care facility for individuals with intellectual disabilities or the individual's guardian, as applicable, may appeal to the facility's specially constituted committee in accordance with the facility's procedure if the individual or guardian, as applicable, is dissatisfied with the strategy or the process used for development of the strategy.
- (g) An individual who does not reside in an intermediate care facility for individuals with intellectual disabilities or the individual's guardian, as applicable, may seek administrative resolution in accordance with rule [5123-4-04](#) of the Administrative Code if the individual or guardian is dissatisfied with the strategy or the process used for development of the strategy.

### **Use of a restrictive measure without prior approval**

1. Nothing in this rule shall be construed to prohibit or prevent any person from intervening in a crisis situation as necessary to ensure a person's immediate health and safety.
2. Use of a restrictive measure, including use of a restrictive measure in a crisis situation (e.g., to prevent an individual from running into traffic), without prior approval in accordance with paragraph (H) of this rule shall be reported as an "unapproved behavioral support" in accordance with rule [5123-17-02](#) of the Administrative Code.

### **Reporting of behavioral support strategies that include restrictive measures**

Each county board and each intermediate care facility for individuals with intellectual disabilities shall enter information regarding behavioral support strategies that include restrictive measures in the department's restrictive measures notification system. Corresponding entries are to be made:

1. After securing approval in accordance with paragraph (H) of this rule and prior to implementation of a behavioral support strategy that includes restrictive measures; and
2. When a restrictive measure is discontinued.

### **Analysis of behavioral support strategies that include restrictive measures**

1. Each county board and each intermediate care facility for individuals with intellectual disabilities shall annually compile and analyze aggregate data extracted from the department's restrictive measures notification application regarding behavioral support strategies that include restrictive measures and furnish the data and analyses to the human rights committee by March fifteenth of each year for the preceding calendar year. Data compiled and analyzed shall include, but are not limited to:
  - (a) Nature and frequency of risk of harm or likelihood of legal sanction that triggered development of strategies that include restrictive measures;
  - (b) Number of strategies that include restrictive measures by type of restrictive measure (i.e., chemical restraint, manual restraint, mechanical restraint, rights restriction, and time-out) reviewed, approved, rejected, and reauthorized in accordance with this policy;

- (c) Number of restrictive measures by type of restrictive measure (i.e., chemical restraint, manual restraint, mechanical restraint, rights restriction, and time-out) implemented;
  - (d) Number of strategies that include restrictive measures that have been discontinued and the reasons for discontinuing the strategies; and
  - (e) An in-depth review and analysis of either:
    - (i) Trends and patterns regarding strategies that include restrictive measures for purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs; or
    - (ii) A sample of implemented strategies that include restrictive measures for purposes of ensuring that strategies are developed, implemented, documented, and monitored in accordance with this rule.
2. County boards and intermediate care facilities for individuals with intellectual disabilities shall make the data and analyses available to the department upon request.

### **1300.061 Behavior Support Policy for Youth – Ages 0 up to 18**

The Clermont County Board of DD recognizes that the developmental care needs of youth are different from those of adults, and critical to their health and development (related to physical, emotional, mental health, and cognitive health).

This policy is created to highlight the specific developmental needs of children and to delineate the difference between what would be identified as rights restrictions for adults and developmentally appropriate care of children. This policy recognizes that children have all the basic human rights of adults. This includes but is not limited to freedom, security, freedom from discrimination and to have voice and choice. This must be balanced with the recognition that the developmental care needs of youth are different from those of adults and critical to their health and development (related to physical, emotional, and cognitive health).

#### **Screen Time:**

The American Academy of Pediatrics (AAP) recommends no screen time for children between the ages of 18-24 months (Except for Video Chatting), and 1 hour or less of screen time for kids ages 2-5. The APA has developed a Family Media Use Plan for older kids, in which parents and children negotiate limits and boundaries around screen usage. It recommends that “for children ages 6 and older, place consistent

limits on the time spent using media, and the types of media, and make sure media does not take the place of adequate sleep, physical activity and other behaviors essential to health.” Furthermore, the AAP recommends designating media-free times, such as dinner, and media-free locations, such as bedrooms, for youth within their place of residence. Stephanie Papas, 2020, What do we really know-kids and Screens. Monitor on Psychology: Apr/May/2020/Pg.42.

Access and exposure to electronics such as TV’s, computers, and other digital devices, often referred to as “screen time,” can be limited due to research suggesting excessive exposure contributes to the cognitive, emotional, and social developmental delays in youth. These imposed limitations for youth under the age of 18 will not require HRC approval.

**Bedtimes:**

“Teens should sleep 8 to 10 hours per night while younger children need even more sleep”, according to new recommendations from the American Academy of Sleep Medicine (AASM). The group lays out optimal amounts of sleep for children of different ages in the June 2015 statement Recommended Amount of Sleep for Pediatric Populations, which has been endorsed by the AAP. “Regularly sleeping fewer than the number of recommended hours is associated with attention, behavior, and learning problems,” according to the statement. “Insufficient sleep also increases the risk of accidents, injuries, hypertension, obesity, diabetes and depression.” Likewise, too much sleep has been linked to obesity, diabetes and mental health problems, the group said. The AASM released the guidance in a two-page statement and plans to further detail the research. Following are the recommended minimum and maximum hours each age group should regularly sleep during a 24-hour period for optimal health: Ages 4-12 months: 12-16 hours (including naps) Ages 1-2 years: 11-14 hours (including naps) Ages 3-5 years: 10-13 hours (including naps) Age 6-12 years: 9-12 hours Age 13-18 years: 8-10 hours. Melissa Jenco (2016) AAP endorses new recommendations on sleep times, AAP News

**Dietary:**

Access to and consumption of foods and drinks with high amounts of sugars, salt, artificial coloring and/or preservatives may be limited due to research suggesting that such foods can contribute to mood instability, sleep difficulties, cognitive delays and/or long-term health damage in youth (Child Development Institute). According to the AAP, eating and drinking too much added sugar puts kids at risk for obesity, tooth decay, heart disease, high cholesterol, high blood pressure, type 2 diabetes, and fatty liver disease, among other health problems: Tricia Koriath (2019) AAP News

These limits will be in place for youth based on physician recommendations and parental guidance.

**Making hazardous items inaccessible:**

Over 2 million human poisonings are reported to poison control centers every year. Children under 6 make up more than half of those poisonings. The most common sources of childhood poisonings are health and beauty products, cleaning products, and medications.

Many child-resistant locks or latches can be put on doors or cabinets to keep young children from getting poisons. Many of these devices lock automatically when the door is closed, and they need an adult's hand or skill to open the door.

Many adult medications, vitamins, marijuana, and other products now look like candy or gummies. Using separate, locked medication cabinets helps prevent child exposure and mistakes that early childhood staff can make. (Caring for Our Children (CFOC); Chapter 5: Facilities, Supplies, Equipment, and Environmental Health;5.2 Quality of the Outdoor and Indoor Environment;5.2.9 Prevention and Management of Toxic Substances)

For children under 6 years old, toxic chemicals may be locked up as a standard practice.

**Structure and Routine:**

Daily structure and routines will be expected for youth and established for each youth according to their individualized needs, preferences, and chronological age. These may include but not be limited to bedtime and morning routine. The use of routines with youth provides them a sense of comfort and security through consistency and predictability, establishes commonly known expectations, aids in their development of healthy and productive habits and offers a sense of stability during times of change and stress.

**Supervision:**

The Clermont County Board of DD acknowledges the importance of recognizing each youth's supervision needs based on their chronological age. Individual plans will include an expected supervision level for each youth. Parents and caregivers need to consider their child's maturity level and their ability to make safe and sensible decisions. Developmental needs and individual preferences will be considered when establishing supervision requirements for youth. Supervision requirements alone will not be considered restrictive for youth under the age of 18. Responses such as

blocking egress, locking doors, other physical interventions will be considered restrictive and require HRC approval.

**General Statements:**

Because every youth we serve is unique and comes to us with diverse, and potentially traumatic life experiences, it is important that an individual's needs supersede any established standard of practice. Although the above practices will serve as the Clermont County Board of DD's standard of care for youth, variations from these standards are appropriate if the following criteria are met:

- The proposed variation is for the purpose of promoting the youth's well-being and developmental growth.
- The proposed variation has been authorized by the youth's parent or guardian.
- The proposed variation has been discussed and agreed upon by the youth's team.

The above-mentioned limits may be included in each person's ISP as an expected part of their daily routine and will not require Human Rights Committee (HRC) oversight. Individual Teams (including parents and guardians) will discuss agreed upon limitations and consider changes in chronological developmental needs during regularly scheduled review processes. Teams will request guidance and advisement from the CCBDD HRC if concerns arise that established limitations for a youth are becoming restrictive and no longer related to the developmental needs based on their chronological developmental age.

**1300.07 Human Rights Committees**

CCBDD shall establish and actively participate in an established human rights committee.

1. The human rights committee shall:
  - (a) Be comprised of at least four persons;
  - (b) Include at least one individual who receives or is eligible to receive specialized services;
  - (c) Include qualified persons who have either experience or training in contemporary practices for behavioral support; and
  - (d) Reflect a balance of representatives from each of the following two groups:
    - (i) Individuals who receive or are eligible to receive specialized services or family members or guardians of individuals who receive or are eligible to receive specialized services; and

- (ii) County boards, intermediate care facilities for individuals with intellectual disabilities or other providers, or other professionals.
2. All information and documents provided to the human rights committee and all discussions of the committee are confidential and shall not be shared or discussed with anyone other than the individual, the individual's guardian, and the individual's team.
  3. Members of the human rights committee shall receive department-approved training within three months of appointment to the committee in:
    - (a) Rights of individuals as enumerated in section [5123.62](#) of the Revised Code;
    - (b) Person-centered planning;
    - (c) Informed consent;
    - (d) Confidentiality; and
    - (e) The requirements of this rule.
  4. Members of the human rights committee shall annually receive department-approved training in relevant topics which may include but are not limited to:
    - (a) Self-advocacy and self-determination;
    - (b) Role of guardians and section [5126.043](#) of the Revised Code;
    - (c) Effect of traumatic experiences on behavior; and
    - (d) Court-ordered community controls and the role of the court, the county board or intermediate care facility for individuals with intellectual disabilities, and the human rights committee.

**1300.08 Ohio Department of Developmental Disabilities (DODD) Oversight**

1. DODD can take immediate action as necessary to protect the health and welfare of individuals which may include, but is not limited to:
  - a. Suspension of a behavioral support strategy not developed, implemented, documented, or monitored in accordance with this rule or where trends and patterns of data suggest the need for further review;
  - b. Provision of technical assistance in development or redevelopment of a behavioral support strategy; and
  - c. Referral to other state agencies or licensing bodies, as indicated.
2. DODD will compile and analyze data regarding behavioral support strategies for purposes of determining methods for enhancing risk reduction efforts and

outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs. The department will make the data and analyses available.

3. DODD may periodically select a sample of behavioral support strategies for review to ensure that strategies are developed, implemented, documented, and monitored in accordance with this rule.
4. DODD will conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with this rule. Failure to comply with this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

### **DODD Waiving of provisions of 5123-2-06**

For good cause, the director of DODD may waive a condition or specific requirement of this rule except that the director shall not permit use of a prohibited measure. The director's decision to waive a condition or specific requirement of this rule shall not be contrary to the rights, health, or safety of individuals receiving services. The director's decision to grant or deny a request is not subject to appeal.

### **1300.09 Mental Health Supports and Services (MHSS)**

CCBDD has completed a Provider Service Plan, which specifies MHSS program mission, vision and goals; a description of services provided; days of service and hours of operation; needs and characteristics of the population served; goals and scope of service; and a description of services which are offered through referral. This plan shall be revised and updated when any changes occur involving services, and is available for review by persons served, their family, significant others, and the public.

### **Confidentiality**

Mental Health Supports and Services ensures confidentiality in accordance with applicable federal and state laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996. Staff access to an individual client's records, treatment information, diagnosis and or other protected information is limited to access and disclosure. Storage of client records shall be in accordance with all applicable federal and state laws and regulations.

## **Records**

The MHSS program will ensure that each individual being served has an individual record that is maintained. An individual's record will include information compiled by therapist pertaining to client health, addiction, and mental health, including but not limited to, assessment of findings and diagnosis, treatment details, and progress notes. Documentation will also be maintained of each signed authorization of release of information, provision and review of client's rights policy and grievance procedure, and verification that the individual was provided with service/program expectations.

## **Drug Theft**

The Agency will investigate and report any Mental Health Program Employee, volunteer, or contract employee that takes, uses, sells, or gives away medication belonging to a client. This will be considered "drug theft". An employee or volunteer with knowledge of drug theft by an employee or any other person shall report such information to their immediate supervisor and the Human Resources Department.

Suspected Drug Theft shall be reported to the Ohio Board of Pharmacy. For controlled substances, suspected drug theft shall also be reported to the Federal Drug Enforcement Administration.

The agency shall take all reasonable steps to protect the confidentiality of the information and the identity of the person furnishing the information.

## **Individualized Service**

The development of the individualized treatment plan (ITP) is a collaborative process between the client and service provider(s) based on a diagnostic assessment, a continuing assessment of needs, and successful identification of interventions/services. The individualized service plan shall document, at a minimum:

- A description of the specific mental health needs of the client;
- Anticipated treatment outcomes based upon the mental health needs identified. Such outcomes shall be mutually agreed upon by the provider and the client. If these outcomes are not mutually agreed upon, the reason(s) needs to be fully documented;
- Name(s) and/or description of all services being provided. Such service(s) shall be linked to a specific mental health need and treatment outcome;
- Evidence that the plan has been developed with the active participation of the client. As appropriate, involvement of the family members, parents, legal guardians/custodians or significant others shall also be documented;

- As relevant, the inability or refusal of the client to participate in service planning and the reason(s) given; and
- The signature(s) of the agency staff member(s) responsible for developing the individualized service plan, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable.

An initial treatment plan may be developed within seven days of completion of the assessment or at the time of the first face to face contact following the assessment, whichever is later. The complete treatment plan must be completed within 5 sessions or one-month admission, whichever is longer.

The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client.

Documentation of the results of such a periodic review shall occur at least annually, and shall include:

- evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians/custodians or significant others;
- as relevant, the inability or refusal of the client to participate and the reason(s) given, and;
- signature(s) of the agency staff member(s) responsible for completing the review, the date on which it was completed; and documented evidence of clinical supervision of staff completing the review, as applicable.

### **Progress Notes**

The MHSS program will document the progress or lack of progress toward achievement of specified goals identified on the ITP and the continuing need for services. This may be done through a brief narrative of checklists. Progress notes will be documented on a weekly basis, and will include at a minimum:

- client identification;
- date, time of day, and duration of service contact;
- a description of the service rendered;
- the assessment of client progress, or lack of progress, and a brief description of same;
- significant changes or events in the life of the client, if applicable;

- recommendation for the modifications to the ITP, if applicable;
- the signature and credentials of the provider of the service and the date of the signature

Documentation in the progress note, or elsewhere in the individual client record, may include a notation addressing the client's risk of harm to self or others, including a review of the client's ideation, intent, plan, access, and previous attempts, if relevant.

### **Discharge Summary**

The Agency will ensure a discharge summary is completed for an individual leaving services that includes the date of admission, the date of the last service provided, the outcome of the service provided, i.e. amount of progress; recommendations made to the client, including referrals made to other community resources; and the medications prescribed by the contracted psychiatrist upon the client's termination from service. Upon the involuntary termination from service, documentation is necessary that the client was informed of his/her right to file an appeal. A dated signature and credentials of the staff member completing this summary is also required.

### **Release of Information**

Each request for information regarding a current or previous client will be accompanied by an authorization for release of information. The authorization for release shall include, but not be limited to:

- full name of the client;
- date of birth of the client;
- the specific information to be disclosed;
- the name of the person or entity receiving the information;
- the date, event, or condition upon which the authorization will expire;
- a statement that the consent is subject to revocation at any time, except to the extent the provider who is to make the disclosure has already acted in reliance upon in;
- the dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client.

### **Consumer Outcomes**

The MHSS program will use a system of data collection to measure outcomes for clients which will include whether treatment plan goals were met, and client's satisfaction with services. This data will be collected minimally at the beginning and end of services.

**MHSS Services**

The MHSS program is committed to providing a physically and psychologically safe environment as a basic foundation and requirement for effective mental health treatment. We have adopted trauma informed treatment practices and strive to create calm and positive surroundings in which individuals can form trusting relationships. The MHSS program does not use any type of seclusion, restraint, or time out in its service delivery.

**Client Rights and Grievances**

CCBDD assures that all clients served by the MHSS program are provided copies of the Client Rights of the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Developmental Disabilities at intake. Staff will review and explain any and all aspects of client rights and the grievance procedure in a manner appropriate for the person's understanding.

During the provision of services in a crisis or emergency situation, the client shall be verbally advised of at least the immediately pertinent rights, such as the right to consent or to refuse the offered treatment and the consequences of that agreement or refusal. Full verbal explanation of the client rights policy may be delayed to a subsequent meeting.

A copy of the client rights policy shall be posted in a conspicuous location in an area of each building operated by the agency that is accessible to clients and the public. It shall also include the name, title, location, hours of availability and telephone number of the client rights officer with a statement of that person's responsibility to accept and oversee the process of any grievance filed by a client or other person or agency on behalf of a client.

The Agency shall assist a client in filing the grievance if needed by the griever, investigation of the grievance on behalf of the griever, and agency representation for the griever at the agency hearing on the grievance if desired by the griever. The grievance procedure shall clearly specify the name, title, location, hours of availability and telephone number of the person's designated to provide the above activities.

A resolution of the grievance cannot exceed twenty working days from the date of the filing of the grievance. Written notification and explanation of the resolution will be provided to the client, or to the griever if other than the client, with the client's permission.

The griever can initiate a complaint with any or all of several outside entities, specifically the Community Mental Health Board; the Ohio Department of Mental Health and Addiction Services; Ohio Legal Rights, the U.S. Department of Health and Human Services; and appropriate professional licensing or regulatory associations. Relevant addresses and telephone numbers must be conspicuously posted.

The agency client rights officer shall assure the keeping of records of grievances received, the subject matter of the grievances, and the resolution of the grievances, and shall prepare an annual summary. The annual summary shall include the number of grievances received, type of grievances, and resolution status of grievances, and shall be forwarded to the Mental Health Board.

The Agency shall notify the community mental health board of any allegation of staff neglect or abuse within 24 hours of the event occurring.

### **Telehealth**

Telehealth means the use of real-time audiovisual communications of such quality as to permit accurate and meaningful interaction between at least two persons, one of which is a certified provider of the service being provided pursuant to Chapter 5122-25 of the Administrative Code. Asynchronous modalities that do not have both audio and video elements are considered telehealth. The MHSS program will comply with the standards of practice and professional conduct: electronic service delivery (internet, email, teleconference, etc.) as outlined in OAC 5122-29-31, and follow all variances allowed by the Ohio Counselor, Social Worker, Marriage, and Family Therapist Board in the delivery of services outlined below. Any staff working with clients using telehealth will receive training on the HIPAA compliant platforms used for virtual meetings, and will shall describe to the client the potential risks associated with receiving telehealth services, and document that the client was provided with the risks and agreed to assume those risks. Staff will have access to multiple platforms, in case problems arise, as well as agency-issued cell phone, to engage clients. Behavioral Health Services Department Release of Information and Progress Note template have been updated to align with rule.

### **Diagnostic Assessment**

The Mental Health Services and Support program shall ensure that all persons referred for Mental Health Services will receive an assessment upon entrance into services. This assessment is a clinical evaluation performed by a licensed therapist that will be age, gender, and culturally appropriate. It will determine diagnosis, treatment needs, and establish a treatment plan to address the mental health needs.

An *initial* assessment must include an evaluation of:

- the presenting problem;
- the risk of harm to self or others;
- the use of alcohol or drugs;
- the treatment history for mental illness or substance use/abuse; and

- a medical history and examination of mental status

A *comprehensive* assessment will expand on the initial assessment and obtain additional information that is required to establish and implement a comprehensive treatment plan and must be *completed within 30 days* of the initial assessment encounter. A person is not required to have an initial assessment prior to receiving a comprehensive assessment.

MHSS may accept initial or comprehensive assessments from other providers as long as they have been completed within the preceding 12 months.

### **Counseling and Therapy**

Counseling and therapy are interactions with a person(s) where the focus is on achieving treatment objectives related to the person's mental illness or emotional disturbance. It involves a face-to-face encounter between a client, group of clients, client and family members, or family member and the therapist. Group counseling and therapy encounters may not exceed a 1-12 therapist to client ratio.

### **Community Psychiatric Supportive Treatment (CPST)**

Community Psychiatric Supportive Treatment (CPST) provides an array of services delivered by community based, mobile individuals on multidisciplinary teams of professionals and trained others. CPST services at CCBDD address individualized mental health needs, and are currently directed towards intellectually disabled adults, their families and providers, and will vary with respect to hours, type of service, level of intensity, all depending on the changing needs of each individual.

The intent of CPST services at CCBDD is to provide specific, measurable and individualized services to each person served. These services are focused on the individual's ability to succeed in the community, to identify and access needed services, and to show improvement in school, work and family (home life) and integration and contributions within the community.

#### **Activities of CPST services must include at least one of the following:**

- Ongoing assessment of needs
- Assistance in achieving personal independence in managing basic needs as identified by the individual
- Facilitation of further development of daily living skills, as identified by the individual

- Coordination of Individualized Service Plans, including service coordination, assistance with accessing natural support systems in the community, and/or linkages to formal community services/systems
- Symptom monitoring
- Coordination and/or assistance in crisis management and stabilization, as needed
- Advocacy and outreach
- Education and training specific to the individuals assessed needs, abilities and readiness to learn
- Mental health interventions that address symptoms, behaviors, thought processes, etc. that assist an individual in eliminating barriers to seeking or maintaining education or employment
- Activities that increase the individual's capacity to positively impact his/her own environment

### **Therapeutic behavioral services (TBS) and psychosocial rehabilitation (PSR)**

These services are an array of activities intended to provide individualized supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services. TBS and PSR may involve collateral contacts and may be delivered in all settings that meet the needs of the individuals.

#### **TBS activities include, but are not limited to the following:**

- Consultation with a licensed practitioner or other eligible provider to assist with the individual's needs and service planning for individual supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services and development of a treatment plan;
- Referral and linkage to other healthcare, behavioral healthcare, and non-healthcare services to avoid more restrictive levels of treatment;
- Interventions using evidence-based techniques;
- Restoration of social skills and daily functioning;
- Crisis prevention and amelioration;

#### **PSR activities include, but are not limited to the following:**

- Restoration, rehabilitation and support of daily functioning to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning;

- Restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community; and
- Rehabilitation and support to restore skills to function in a natural community environment.

### **Method of Service Delivery**

CPST services can be provided directly to the individual being served, and/or to anyone else who will be assisting in the person's mental health treatment. Service delivery may be face-to-face, by telephone, and/or video conferencing, and may be done individually or in groups.

CPST services are not site specific and may be provided in any setting which meets the needs of the person served. If an individual is living in a supportive residential setting, CPST services must be provided by a distinct staff, separate from the residential staff.

### **Roles, Responsibilities and Qualifications**

At CCBDD, a MHSS therapist will be assigned the responsibility of case coordination of CPST services. This staff will have the capacity to delegate CPST services to eligible providers, both internally and externally, as long as all delegated activities are consistent with this policy in its entirety.

The delegated CPST service may be provided by an entity not certified by ODMHAS as long as there is a written agreement between CCBDD and the non-certified entity that defines the service expectations, qualifications of staff, program, and financial accountability, health and safety requirements, and required documentation.

Entities, both internal and external, agreeing to provide CPST services must have a staff development plan based upon identified individual needs of the CPST staff. Evidence that the plan is being followed must be maintained. The plan must address, at a minimum, the following:

- An understanding of systems of care, such as natural support systems, entitlements and benefits, inter- and intra-systems of care, crisis response systems and their purpose, and the intent and activities of CPST;
- Characteristics of the population to be served, such as psychiatric symptoms, medications, culture, and age/gender development; and
- Knowledge of CPST purpose, intent and activities.

Staffs who have met the requirements of a Qualified Behavioral Health Specialist will be eligible to provide CPST services/activities.

### **Teaming process**

Upon completion of a mental health assessment, and identification and agreement by and individual that CPST services are necessary, the counselor and individual will identify potential members of the multidisciplinary. The counselor will coordinate bringing those team members together, identifying activities specific staff or entities will provide, and assessing the progress achieved with through those activities. The counselor will obtain documentation as service delivery and monitor team efforts. As with other services on the ISP, the counselor will be responsible for determining progress/completion/deletion of goals as directed and requested by the individual served.

### **Evaluation**

A MHSS counselor will work with the Director of Behavioral Health Services to develop a data collection plan to demonstrate efficacy and utilization.

### **1300.10 Sexual Health and Wellness Education**

Persons with developmental disabilities have the right to sexual expression that is exercised in a socially appropriate and responsible manner and does not infringe upon the rights of others.

CCBDD shall offer to individuals eligible for Board services who have indicated that they are willing participants, the opportunity to participate in educational programs which focus upon sexual health and wellness. Classes shall be provided based upon an approved curriculum. All classes related to sexuality education shall be conducted by trained staff.