**R539. Health and Human Services, Services for People with Disabilities.**

**R539-4. Behavior Interventions.**

**R539-4-1. Authority and Purpose.**

(1) Subsections 26B-6-403(2)(g) and 26B-6-403(2)(l) authorize this rule.

(2) This rule defines and establishes a standard for behavior interventions to prevent infringement of a person's constitutionally protected rights without due process. The standard is intended to:

(a) protect and promote a person's rights;

(b) prevent abuse and neglect;

(c) encourage positive behavior support;

(d) ensure health and safety; and

(e) ensure that the least intrusive behavior intervention is provided in the minimum amount necessary.

**R539-4-2. Definitions.**

Terms used in this rule are defined in Section 26B-6-401 and Rules R501-1 and R539-13. Additionally:

(1) "Applied behavior analysis" or "ABA" means a well-developed discipline based on a mature body of scientific knowledge and established standards for evidence-based practice.

(a) ABA focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in behavior.

(b) ABA is a behavioral health treatment that is intended to develop, maintain, or restore, to the maximum extent attainable, the functioning of a person who requires behavioral intervention.

(c) ABA-based therapies are characterized by reliable empirical evidence and are not experimental or investigational.

(2) "Aversive stimulus" means a highly undesirable stimulus change or condition that exceeds what typically occurs in the environment, but is not harmful.

(3) "Contingent rights restriction" means a temporary loss of a human right based on the occurrence of a previously identified unwanted target behavior.

(4)(a) "Deprivation" means the non-contingent removal of or limiting access to a person's stimuli or a person's ability to access stimuli with that person's own available funds to increase the stimuli's value as a potential reinforcer. The potential reinforcer is given to the person contingent on the occurrence of a desired targeted adaptive behavior or another desired targeted response.

(b) If a person does not own an item or has insufficient funds to purchase an item, the removal of or limiting access to that item is not deprivation.

(5) "Emergency behavior intervention" means the temporary use of an intrusive behavior intervention, including an emergency rights restriction, not outlined in a person's behavior support plan and only used in an emergency situation to prevent:

(a) imminent injury to the person or any other person; or

(b) significant property damage.

(6) "Emergency rights restriction" means a temporary loss of a human right based upon the occurrence of a previously identified unwanted target behavior.

(7) "Enforced compliance" means a person is physically guided through completion of a request or command and the person is more than minimally resisting.

(8) "Error correction" means a person repeating the step of a skill where an error was made, while:

(a) receiving as much help as needed to complete the skill without making additional errors; and

(b) the person is not resisting throughout the process.

(9) "Extinction" means the reinforcement that maintained or increased the unwanted target behavior is withheld.

(10) "Functional behavior assessment" means a systematic assessment for obtaining information about the function an unwanted target behavior serves for a person. A qualified behavior professional shall conduct this assessment.

(11) "Intrusive behavior intervention" means an intervention of an unpleasant and restrictive behavior with the potential to restrict a person's human right and affect the safety of the person.

(12)(a) "Manual restraint" means a person's body physically held or restricted in a way that:

(i) prevents that person's free movement; and

(ii) is administered in a way that ensures that person's general safety with specific emphasis on appropriate breathing and circulation.

(b) Manual restraint does not mean briefly holding a person, who is not resisting, to calm that person or escort that person safely from one area to another.

(13) "Mechanical restraint" means a device attached to or adjacent to a person's body that:

(a) cannot easily be removed by the person;

(b) restricts the person's freedom of movement; and

(c) is administered in a way that ensures a person's general safety with specific emphasis on appropriate breathing and circulation and which prevents skin irritation.

(14) "Non-intrusive behavior intervention" means a positive behavior intervention that incorporates positive teaching, prevention, reinforcement, and training strategies.

(15) "Physical guidance" means a person's appropriate body part being physically guided through a proper motion by a caregiver or staff while the person is no more than minimally resisting.

(a) If a person demonstrates any level of resistance, the behavior intervention is considered intrusive behavior intervention.

(b) Physical guidance may include partial or full physical prompts.

(16) "Positive behavior support" means the use of a positive behavior intervention that achieves a socially important behavior change. The support:

(a) addresses the functionality of a problem;

(b) focuses on prevention and teaching replacement behavior; and

(c) results in an outcome that is acceptable to the person, the family, and the community.

(17) "Positive practice overcorrection" means a person repeatedly practicing a positive alternative behavior in a situation when an unwanted target behavior commonly occurs.

(18) "Reinforcement" means anything that occurs following a behavior that increases or strengthens that behavior.

(19) "Replacement behavior" means a necessary behavioral, communication, or social skill used to replace an unwanted target behavior.

(20) "Response-cost" means that previously obtained rewards, including points, tokens, activities, or the opportunity to exchange points or tokens to obtain a reward, are removed from a person for a time, contingent upon the occurrence of an unwanted target behavior.

(21) "Restitutional overcorrection" means that a person repeatedly restores an environment to its original condition.

(22)(a) "Satiation" means a person is non-contingently presented with an overabundance of a reinforcer to decrease its reinforcing properties and subsequently decrease the occurrence of the unwanted target behavior.

(b) Satiation may not be used in conjunction with enforced compliance.

(23)(a) "Seclusion" means the same as defined in Section 26B-2-101 and Rule R501-1 and includes social isolation and removing the person from a specific setting that exceeds ten minutes.

(b) Seclusion is not a voluntary time-out or medical quarantine and isolation when approved by a medical professional.

(24)(a) "Seclusion room" means that a person is placed alone in a room designed for seclusion for up to an allowable specified amount of time, as determined by the behavior support plan.

(b) Use of the seclusion room may require enforced compliance to move the person to or prevent them from leaving the seclusion room.

**R539-4-3. Review Committees.**

(1) Each person with a behavior support plan and who uses a provider service shall have access to a provider peer review committee and the State Behavior Review Committee.

(2) Each person with a behavior support plan who is a resident of the developmental center shall have access to the State Behavior Review Committee.

(3) A provider peer review committee shall consist of at least three specialists.

(a) Each specialist shall have experience in the fields of positive behavior support and ABA.

(b) At least one of the three specialists may not be employed by the provider.

(4) A provider peer review committee shall evaluate a behavior support plan for:

(a) compliance with the least intrusive standard;

(b) effectiveness; and

(c) quality of design and implementation.

(5) The State Behavior Review Committee shall consist of at least three professionals.

(a) Each professional shall have training and experience in ABA.

(b) At least one professional shall be an employee of the division.

(6) The State Behavior Review Committee shall:

(a) review each behavior support plan for effectiveness and compliance with the least intrusive standard; and

(b) determine if the behavior support plan may be used.

(7) For each intervention training program, the State Behavior Review Committee and a medical professional shall:

(a) review each curriculum and manual restraint procedure;

(b) determine if the curriculum or manual restraint procedure may be used; and

(c) keep a copy of the curriculum for each approved intervention training program.

**R539-4-4. Behavior Support Plans.**

(1) Each behavior support plan shall be based on the results of a functional behavior assessment conducted by a qualified behavior professional.

(a) The functional behavior assessment guides the design of each behavior intervention and shall include:

(i) a clear description of an unwanted target behavior exhibited by a person;

(ii) any situation that predicts when an unwanted target behavior will likely occur;

(iii) any consequence that maintains the desired target behavior; and

(iv) a summary statement or hypothesis.

(b) The functional behavior assessment may include any checklist, direct observation, interview or other helpful information.

(2) Each behavior support plan shall use the principles of ABA or any other intervention consistent with best practice and research on effectiveness that is directly related to a person's goals.

(a) A behavior support plan is a modification to a person-centered support plan and shall use the least intrusive, effective intervention designed to assist a person with:

(i) acquiring or maintaining a skill; or

(ii) preventing an unwanted target behavior.

(b) Staff shall provide the least intrusive intervention in the minimum amount necessary for a purpose that includes:

(i) preventing harm to the person;

(ii) preventing harm to any other person; or

(iii) reducing property damage.

(c) A behavior support plan shall include:

(i) an individualized assessed need;

(ii) a clear description of the behavior intervention;

(iii) a focus on prevention;

(iv) a method to teach a replacement behavior;

(v) a planned response to an unwanted target behavior;

(vi) a data collection system to evaluate at least annually the effectiveness of the plan and determine if a modification may be ended;

(vii) documentation of each positive behavior intervention and support used before modifying the behavior support plan and person-centered support plan;

(viii) documentation of each less intrusive method of meeting the need that was previously used and did not work, including an explanation of why the method did not work;

(ix) an assurance that each behavior intervention and support cause no harm to the person; and

(x) the informed consent of the person.

(d) A behavior intervention included in a behavior support plan shall comply with Section R539-3-9.

(3) A non-intrusive behavior intervention may be used informally and without approval.

(a) A provider shall document each non-intrusive behavior intervention in a written support strategy or a behavior support plan.

(b) A non-intrusive behavior intervention includes:

(i) error correction;

(ii) extinction;

(iii) positive behavior intervention;

(iv) positive behavior supports;

(v) positive practice overcorrection; and

(vi) reinforcement.

(c) Use of a non-intrusive behavior intervention shall comply with Section R539-3-9.

(4)(a) A behavior support plan that includes an intrusive behavior intervention requires review and approval at least annually by:

(i) a provider peer review committee as described in Section R539-4-3; and

(ii) a provider human rights committee as described in Section R539-3-3.

(b) Any intrusive behavior intervention shall be directly proportionate to the assessed need.

(c) An intrusive behavior intervention shall be included in the behavior support plan as described in Section R539-4-6.

(d) The provider peer review committee and the provider human rights committee shall promote use of a non-violent intervention or a de-escalation technique.

(5) A behavior support plan may only be implemented after:

(a) a provider peer review committee approves any intrusive behavior intervention;

(b) the team approves the behavior support plan; and

(c) the person gives informed consent.

(6) A person must consent to a behavior support plan before implementing the plan.

(a) If a person does not consent to a behavior support plan approved by the team, the provider human rights committee shall:

(i) review the behavior support plan; and

(ii) make a recommendation to the person and the team about how to proceed.

(b) The person may appeal the provider human rights committee decision to the Division Human Rights Council, as defined in Section R539-3-2.

(7)(a) A provider must provide adequate training on a behavior support plan to each staff involved in implementing a procedure outlined in the behavior support plan before implementation.

(b) The provider shall document and keep a record of training completion.

**R539-4-5. Emergency Behavior Interventions.**

(1)(a) An emergency behavior intervention may be used if imminent danger is present or threatened, including:

(i) imminent injury to a person or any other person; or

(ii) property destruction.

(b) If possible, a provider shall exhaust any non-intrusive behavior intervention before implementing an emergency behavior intervention.

(2) Use of an emergency behavior intervention shall comply with Section R539-3-9.

(3) An emergency behavior intervention requires additional oversight, approval, and review.

(a) A manual restraint may be used as described in Section R539-4-6.

(b) A mechanical restraint may be used as described in Section R539-4-6.

(c) In order for staff to use a seclusion room as an intervention, a provider administrator or qualified behavior professional must approve the use of the seclusion room, as described in Section R539-4-6, within 15 minutes of staff initiating each intervention.

(i) If a provider administrator or qualified behavior professional does not approve the use of a seclusion room within 15 minutes of staff initiating the use of the seclusion room as an intervention, staff shall release the person from the seclusion room.

(ii) Staff must have approval from a provider administrator or qualified behavior professional before shutting the door or holding the door shut.

(d) If a provider uses an emergency behavior intervention for three or more incidents or for a total of 25 minutes or longer within 30 consecutive days, then the team shall meet within ten business days of the most recent emergency behavior intervention to determine if:

(i) any medical or environmental factor is causing the behavior;

(ii) the person needs a behavior support plan;

(iii) a non-intrusive behavior intervention is needed in the person's behavior support plan;

(iv) an intrusive behavior intervention is needed in the person's behavior support plan;

(v) additional medical, mental health, or other professional assistance is needed; or

(vi) another solution is available to help the person avoid or prevent future use of an emergency behavior intervention.

(e) A provider human rights committee or provider peer review committee shall review each emergency behavior intervention incident report during the next regularly scheduled committee meeting or within 30 days of the date of each emergency intervention.

(4) Any emergency behavior intervention:

(a) shall be considered reasonable and necessary under the circumstances;

(b) shall result in an emergency rights restriction;

(c) may not be used as a substitute for the behavior support plan;

(d) may not be used for a length of time longer than is necessary to ensure the health and safety of any person in imminent danger; and

(e) may not exceed an amount of force considered reasonable and necessary under the circumstances.

(5) If prolonged use of an emergency intervention occurs, staff shall seek assistance from the provider's administrator and any public safety service needed under the circumstances.

(6) For each occurrence of an emergency behavior intervention, a provider shall submit a critical incident report through the division's case management system. An incident report requires the same information as described in Rule R501-1.

(7) The incident report shall be reviewed by the person's support coordinator.

(a) The provider shall communicate each follow-up action to the person's support coordinator.

(b) The support coordinator shall document each follow-up action taken.

**R539-4-6. Intrusive Behavior Intervention.**

(1) If a provider or the developmental center uses an intrusive behavior intervention, the intrusive behavior intervention shall be:

(a) identified in the behavior support plan; and

(b) used immediately after a person engages in an unwanted target behavior identified in the behavior support plan.

(2) An intrusive behavior intervention includes:

(a) aversive stimulus;

(b) contingent rights restriction;

(c) deprivation;

(d) emergency rights restriction;

(e) enforced compliance;

(f) manual restraint;

(g) mechanical restraint;

(h) physical guidance;

(i) response-cost;

(j) restitutional overcorrection;

(k) satiation;

(l) seclusion; and

(m) seclusion room.

(3) To include an intrusive behavior intervention in the behavior support plan, a provider or the developmental center shall describe the:

(a) method of intervention;

(b) safety and efficacy monitoring procedure; and

(c) time limitation or individualized release criteria.

(4) Individualized release criteria for manual restraint, mechanical restraint, seclusion, and seclusion room shall be based on:

(a) a predetermined behavior that shall be achieved; or

(b) a predetermined amount of time spent in restraint or seclusion.

(5) Aversive stimulus shall be free from any procedure or action that is degrading, humiliating, harsh, punitive, painful, or abusive. A provider and the developmental center may not use:

(a) a device that transmits an electric shock to the person;

(b) heat or cold exposure; or

(c) any procedure or action likely to result in psychological or physical trauma.

(6) Except when approved by a provider administrator or a qualified behavior professional as described in Subsection (6)(a), use of a manual restraint, mechanical restraint, or seclusion may not exceed one hour.

(a) If the predetermined behavior release criteria in the person's behavior support plan is not met within one hour of beginning the restraint or seclusion, one additional hour may be approved.

(b) The team and the provider peer review committee shall review any use of restraint or seclusion that exceeds one hour.

(c) Any time that the person spends asleep shall be counted toward the predetermined amount of time in the release criteria.

(d) Total time spent in restraint or seclusion may not exceed two hours in a 24-hour period.

(7) Staff shall complete:

(a) detailed documentation of each use of a manual restraint, mechanical restraint, or seclusion; and

(b) any observation requirement included in the behavior support plan.

(8)(a) A provider or the developmental center shall submit each mechanical restraint, seclusion, or seclusion room included in the behavior support plan to the State Behavior Review Committee for review.

(b) The State Behavior Review Committee must approve the intervention before it may be used.

(9) A manual restraint shall be used as described in Rule R501-1 and this section.

(a) A manual restraint program or procedure may be used after approval by the State Behavior Review Committee and the Division Human Rights Council.

(b) Intervention training programs currently approved by the State Behavior Review Committee include:

(i) Crisis Prevention Intervention (CPI);

(ii) Safety Care;

(iii) Supports Options and Actions for Respect (SOAR)

(iv) the Mandt System; and

(v) the Professional Assault Response Training (PART).

(10) A provider shall only use a mechanical restraint as described in Subsections (10)(a) through (c).

(a) A safety and efficacy monitoring procedure shall ensure a person's health and safety. Each procedure shall:

(i) be individualized;

(ii) include a method to monitor the person before, during, and after use of a mechanical restraint; and

(iii) include observation and documentation of the person's status at a minimum of 15-minute intervals.

(b) A mechanical restraint device includes a helmet, gloves, mitts, splints, and any wrist or ankle binding.

(c) A mechanical restraint device does not include:

(i) a device commonly used to ensure a person's safety, such as seatbelts or protective sporting equipment;

(ii) medically necessary equipment related to a health condition used to promote healing or to prevent injury; and

(iii) a protective helmet used to limit injury to a person during a seizure or for another medical reason.

(11) Seclusion shall be used as described in Rule R501-1 and this subsection.

(a) A seclusion room may be used as follows:

(i) A provider licensed through the Office of Licensing may use a seclusion room as described in Rule R501-1.

(ii) A provider not licensed through the Office of Licensing and the developmental center may use a seclusion room as described in Rule R501-1 and use the seclusion room for an adult or child.

(iii) The developmental center may not use a seclusion room as an emergency behavior intervention as described in 42 CFR 483.450(c)(1)(i), incorporated by reference in Rule R529-3.

(b) To include seclusion or a seclusion room in a behavior support plan, a provider must describe the individualized release criteria for each intervention as described in Subsection (3).

(c) Staff shall maintain constant visual and auditory observation of a person during each seclusion and use of a seclusion room.

(12) The division director must approve the use of a seclusion room before that intervention may be used.

(a)(i) A provider or the developmental center shall request that the State Behavioral Review Committee review the use of a seclusion room in a behavior support plan.

(ii) The behavior support plan shall include a procedure for ensuring:

(A) the person's health and safety;

(B) that staff maintain constant visual and auditory observation of the person;

(C) observation and documentation of the person's status at a minimum of 15-minute intervals; and

(D) that staff open the door if the person falls asleep before release from the seclusion room.

(b) The State Behavior Review Committee may recommend that a behavior support plan include that a provider be allowed to shut a door or hold a door shut during use of the seclusion room.

(i) The recommendation shall be based upon adequate justification and documentation.

(ii) The use of a seclusion room as a behavior intervention shall help the person be more safely served within the division support system.

(c) The State Behavioral Review Committee shall send a behavior support plan and committee recommendation to the Division Human Rights Council for review.

(d) The division director may approve use of a seclusion room on a case-by-case basis after reviewing the recommendation of the State Behavioral Review Committee and Division Human Rights Council.

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