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Client Alert: Proposed Changes to Behavioral Health Service Rules: Key Changes for Ohio Providers to Review

The Ohio Department of Behavioral Health (DBH) recently proposed numerous changes to Ohio Administrative Code (OAC) Chapter 5122-29, which governs the behavioral health services that DBH-certified providers may provide. The proposed rule changes would rescind and replace several existing rules, amend others, and create a new service category and rule for adult crisis services.

The existing rules summarized below (OAC 5122-29-03 through 5122-29-29) are currently under Common Sense Initiative (CSI) review and may be subject to additional changes. The new adult crisis services rule (OAC 5122-29-32) is scheduled for a public hearing on November 16, 2026.

The table below does not provide a comprehensive summary of every proposed rule change in OAC Chapter 5122-29. Proposed rules that only had stylistic changes, not substantive changes, were not summarized. Additionally, proposed rules for certain certified services, including forensic evaluation, driver intervention programs, intensive home-based treatment, among others, were not summarized for purposes of this Client Alert.

A summary of the proposed rules is below.

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Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-03	General services	Rescind in full and replace with new rule	• Defines “general services” as assessment, medical, and counseling and therapy activities. • Requires general services to be provided by the professionals listed in Appendix A, within their scope of practice; Substance Use Disorder (SUD) intensive outpatient (American Society of Addiction Medicine (ASAM) level 2.1) and partial hospital (ASAM level 2.5) services must follow ASAM Criteria. Note: Appendix A is not included in the proposed rule change. • Creates definition for “assessment” to be conducted by qualified staff to determine an individual’s diagnosis and inform treatment plans to address an individual’s primary or co-occurring mental illness and/or substance use disorder, problem gambling, or tobacco/nicotine use. • Sets minimum elements for an initial assessment: presenting problem, risk of harm, alcohol/drug use, treatment history, and medical history/examination. • Requires a comprehensive assessment within 30 days of the initial assessment encounter; however, an initial assessment is not a prerequisite to a comprehensive assessment. • Requires assessments to follow standards of The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council of Accreditation, ASAM, or other director-designated entities. • Permits a provider to accept an initial or comprehensive assessment completed by another provider within the last 12 months. • Defines “counseling and therapy” as “an interaction with an individual or group of individuals that focuses on achieving treatment objectives related to mental illness and/or substance use disorder, problem gambling, tobacco or nicotine use, and/or co-occurring conditions”. • Provides that group counseling and therapy encounters must maintain no greater than a 1:12 ratio (one behavioral health professional to 12 clients). • Defines “medical activities” as (1) performed within the scope of practice of an individual licensed by the State Medical Board of Ohio, the Ohio Board of Nursing, or a pharmacist licensed by the Ohio Board of Pharmacy and (2) intended to address the behavioral and other physical health needs of clients receiving treatment for psychiatric symptoms or substance use disorders. • Provides examples of medical activities, such as performing health care screenings, performing vital signs, ordering laboratory tests, and prescribing.

Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-06	Mental health day treatment service	Amendment	• Clarifies that a mental health day treatment program is to consist of a minimum of two hours and up to a maximum of seven hours per day, at least three days a week, of scheduled intensive activities. • Updates psycho-educational interventions to focus on “recovery” in place of rehabilitation and acceptance language. • Adds to the list of scheduled intensive activities to include (1) treatment for medical, psychological, or psychiatric needs identified in an individual’s ongoing assessment and (2) ongoing monitoring to assess changes in symptom severity, level-of-care needs, and functioning to help identify participant progress and support recovery goals. • Clarifies that mental health day treatment services are to be provided and supervised by an interdisciplinary team of mental health treatment staff, with each staff member acting within the scope of their credentials/qualifications. • Defines “substance use disorder case management services” as activities that help an individual access medical, social, educational, and other services essential to meeting the client’s basic human needs. Case management services include interactions with the client’s family members. • Requires SUD case management services to be delivered by individuals familiar with the community resources in which they provide the services. • Requires SUD case management services to be provided in accordance with the client’s individualized treatment plan. • Clarifies that SUD case management services do not include (1) transportation, (2) waiting with an individual for appointments at social service agencies, court hearings, and similar activities, (3) direct services to which the client has been referred such as medical, educational, or social service, or (4) internal quality assurance activities. • Redefines the population for peer support services as individuals with mental illness or substance use disorder (or both), who may also have a co-occurring developmental or intellectual disability, and their caregivers and families. • Clarifies that peer support services are non-clinical. • Expands and updates the list of peer support services, including new items for peer-led recovery groups, recovery plans, mentoring based on lived experience, engagement in behavioral health services, and engaging additional supports.
OAC 5122-29-13	SUD case management services	Rescind in full and replace with new rule	
OAC 5122-29-15	Peer support services	Amendment	

Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-16	Peer run organization service	Rescind in full and replace with new rule	• Defines “peer run organization service” as activities delivered by individuals, a majority of whom have direct lived experience with mental illness or a substance use disorder, that leverage shared lived experience to promote the recovery and wellbeing of others. • Clarifies that, to be certified, a provider must be able to provide both (1) recovery supports and (2) peer support services by certified peer supporters that are not part of an individualized treatment plan or reimbursed through Medicaid or private insurance (grants and other public funding do not count as reimbursement). • Establishes that a provider must be able to provide one or more of the following activities: Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH) consultation, recovery planning, recovery meetings, support and skills-building groups, Substance Abuse and Mental Health Services Administration (SAMHSA)-supported harm reduction activities, education, wellness and socialization activities, meals, structured volunteer/work activities, outreach and advocacy, and recovery celebrations. • Requires at least 51 percent of the governing board to self-identify as having lived experience and being in recovery (or, for family/caregiver-focused organizations, as caregivers of an individual with mental illness or SUD). • Requires published, predictable hours and requires the service to be open to all community members with mental illness or SUD (not limited to a particular housing program, treatment provider, agency, or facility), with supporting outreach materials, policies, and attendance/intake records. • Permits use of mobile units (vans or larger vehicles, not owned or rented by staff or board members, with a valid license plate and registration on file) in addition to the required physical site, and permits telehealth delivery of peer support services.

Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-17	Community psychiatric supportive treatment (CPST) service	Rescind in full and replace with new rule	• Describes (PSR) as a service for individuals with a mental health diagnosis resulting in functional deficits who need intensive community support, tailored to the individual's treatment plan and delivered at a fixed site, the home, or in the community. • Clarifies that, to be certified, a provider must be able to provide all listed activities: ongoing needs assessment, assistance with managing basic needs, daily living skills development, treatment plan coordination, symptom monitoring, crisis management and stabilization, education and training, mental health interventions, and positive impact activities. • Permits delivery to groups or individuals, face-to-face, by telephone, or by video; requires an interdisciplinary team, staff separate from residential services, a designated case coordinator for each individual, and a staff development plan. • Allows practitioners with a high school diploma and specific training to perform certain activities and allows a provider to contract with another certified provider for one or more activities. • Defines therapeutic behavioral services as intensive, short-term, one-on-one or group outpatient services for individuals with a mental health diagnosis, focused on reducing high-risk, disruptive, or self-destructive behaviors, deliverable in any setting meeting the individual's needs. • Clarifies that, to be certified, a provider must be able to provide collateral contact, evidence-based techniques, strengths-based treatment planning, restoration of self-management skills, and crisis prevention and amelioration, and must monitor symptom severity, level-of-care needs, and functioning. • Requires services to be provided by practitioners with at least a bachelor's or master's degree in social work, psychology, nursing, or a related human services field and/or qualified behavioral health specialists.
OAC 5122-29-18	Therapeutic behavioral services	Rescind in full and replace with new rule	

Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-27	Supplemental behavioral health services	Rescind in full and replace with new rule	• Defines “supplemental behavioral health services” as services not otherwise listed in the chapter, such as representative payeeship, outreach, screening, education, and other supportive behavioral health services which may be offered by entities such as YMCAs, churches, or county family and children first councils. • Requires applications for initial, renewal, or added certification to include a letter of support from each ADAMH board where the services will be provided. • Requires providers to meet appropriate standards; ensure staff are trained on basic information about mental illness, emotional disturbance, and SUD; and develop mechanisms to receive feedback from individuals served. • Defines “approved fidelity review” to mean a fidelity review conducted by an independent validation entity recognized by DBH. • Describes ACT as a 24/7 service for individuals with severe and persistent mental illness needing high service intensity (and their families and support systems), intended to promote recovery and success in employment, housing, and community stability. • Requires ACT teams to meet fidelity criteria using the tool for measurement of assertive community treatment (TMACT) or Dartmouth Assertive Community Treatment Scale (DACTS); a minimum fidelity score of 3.0 before initial certification; fidelity reviews every 12 months; and a minimum score of 4.0 within three years of the initial review and at every review thereafter. • Requires a provider whose team fails to achieve 4.0 to either request a waiver under OAC 5122-25-10 (waivers and variances) (with the latest fidelity report, a proposed timeframe, a fidelity action plan, and an internal steering committee) or disband the team; requires that action plans be addressed in the quality improvement plan, and authorizes the department to require a new fidelity review based on noncompliance. • Requires the team, before terminating services for unexpected non-participation, to attempt at least two contacts per month for 90 days (documented in the record) unless the individual asks to discontinue; requires staff to be qualified and act within their credentials.
OAC 5122-29-29	Assertive community treatment (ACT) services	Rescind in full and replace with new rule	• Requires a provider whose team fails to achieve 4.0 to either request a waiver under OAC 5122-25-10 (waivers and variances) (with the latest fidelity report, a proposed timeframe, a fidelity action plan, and an internal steering committee) or disband the team; requires that action plans be addressed in the quality improvement plan, and authorizes the department to require a new fidelity review based on noncompliance. • Requires the team, before terminating services for unexpected non-participation, to attempt at least two contacts per month for 90 days (documented in the record) unless the individual asks to discontinue; requires staff to be qualified and act within their credentials.

Rule Number	Tagline	Type of Filing	Summary of Content and Proposed Changes
OAC 5122-29-32	Adult crisis services	New service category and rule	• Note that a hearing will be held on this new rule on November 16, 2026. • Defines “adult crisis service” as a continuum of in-person activities for an individual age 21 or older in a crisis that does not appear imminently life-threatening. The service is intended to prevent escalation, keep the individual safe, stabilize the individual, and strengthen community ties so the individual can be supported there after the crisis. • Requires individuals ages 18 to 20 to be referred to the local Mobile Response and Stabilization Service (MRSS) regional provider within 15 minutes of arrival; the adult crisis provider must triage, observe, and monitor the individual until the MRSS provider arrives. • Establishes three levels of care: Level I, behavioral health urgent care (BHUC) (lowest acuity); Level II, crisis receiving and observation (intermediate acuity); and Level III, crisis stabilization (an alternative to hospital admission that must be delivered at a Class One residential facility). • Requires the service to include, at a minimum, triage or admission, initial or comprehensive assessment, behavioral health interventions, observation and monitoring, safety planning, referral and case management, and discharge planning. • Clarifies that, to be certified, a provider must already hold DBH certification for general services (OAC 5122-29-03), SUD case management services (OAC 5122-29-13), peer support services (OAC 5122-29-15), CPST service, and therapeutic behavioral services and psychosocial rehabilitation (OAC 5122-29-18); a provider offering Level III care must also hold a Class One residential facility license from DBH. • Requires staffing of (1) at least one licensed mental health clinician or psychologist (or trainee), on-site during all hours for Level I and on-site from 8:00 a.m. to 8:00 p.m. (with telehealth availability at other times) for Levels II and III; (2) at least one RN or LPN on-site during all operating hours; (3) at least one certified peer supporter or qualified behavioral health specialist on-site during all operating hours; and (4) at least one qualified prescriber (e.g., a psychiatrist or a physician, APRN, or physician assistant meeting specified experience or qualification requirements) on-site or available by telehealth during all operating hours. • Requires Level I services to be available at least five days a week, eight hours a day, between 7:00 a.m. and 7:00 p.m., based on community needs, and Levels II and III to be available 24 hours a day, seven days a week, including holidays.

Shumaker’s Health Law Service Line will continue to closely monitor the status of the OAC Chapter 5122-29 rules in CSI review. Providers interested in commenting on the proposed adult crisis services rule should

prepare for the November 16, 2026 hearing.

If you have any questions about the proposed rule changes or want assistance participating in the public comment process, please contact Daphne Kackloudis, Jordan Burdick, or Kate Crawford.