

**Ohio Attorney General’s Task Force on Criminal Justice and Mental Illness
Psychiatry and Treatment Subcommittee**

Proposed Legislation for Court-Ordered Outpatient Treatment

A Summary of Input from Interested Parties on SB 350 (Now SB 43)

The Ohio Attorney General’s Task Force on Criminal Justice and Mental Illness was initiated in December 2011 by Attorney General Mike DeWine and Ohio Supreme Court Justice Evelyn Stratton (retired) with an overall goal statement of: “To find ways to increase public safety and reduce the number of persons with mental illness trapped in the criminal justice system.” Ten subcommittees were formed to support this goal. The Psychiatry and Treatment subcommittee’s purpose includes: “Enhance treatment for people with mental illness who are involved or at risk for involvement in the Criminal Justice System.”

Senate Bill 350, sponsored and introduced by Senator Dave Burke in 2012, focuses on Court-Ordered Outpatient Treatment for persons with severe mental illness who meet specific criteria.¹ The National Alliance on Mental Illness of Ohio (NAMI Ohio) was significantly involved with the development of the content of this proposed legislation.

Senate Bill 350 had strong support and opposition from many key groups. The Psychiatry and Treatment Sub-Committee designed an active and balanced input process to gather information from proponents and opponents. Input was also gathered from “interested parties.” The Sub-Committee developed a set of questions intended to elicit responses from these groups. Each participant received the same input questions in advance and was asked to present a verbal and written response to each question. A neutral facilitator provided management of the input process. After providing input, audience members were invited to write and submit questions for clarification purposes. These questions, then, were asked of the presenter by the facilitator.

NAMI Ohio had representation at all input sessions and spent time with some of the presenters to gain additional understanding of statements of support and opposition that had been presented during the formal input process. As a result of this process, NAMI Ohio recommended certain changes in the bill’s language that have been incorporated in the bill, reintroduced as S.B. 43.

The information contained in this document includes:

- A letter from NAMI Ohio regarding their response to input gathered from this process and targeted changes to be included in the reintroduced bill;

¹ Senate Bill 350 was reintroduced by Senator Dave Burke and Senator Charleta Tavares on February 14, 2013, as Senate Bill 43. http://www.legislature.state.oh.us/bills.cfm?ID=130_SB_43

- A schedule and names of key stakeholders who presented as well as organizations they represented;
- Questions asked of all participants;
- A copy of the input by each stakeholder;
- Membership of the Psychiatry and Treatment Sub-Committee.

The Psychiatry and Treatment Sub-Committee expresses appreciation to all stakeholders who provided input. As would be expected in such a process, strongly felt positions were presented. All presenters were thoughtful and thorough in their responses. Most significant throughout the process was the degree of respect and civility that was maintained as proponents, opponents and interested parties participated. While it is not possible to summarize all content, most notable are the following:

- The existing Ohio Court-Ordered Outpatient Treatment Law has different interpretations and is unevenly accessed and/or used across Ohio's eighty-eight counties;
- Family members of persons with severe and persistent mental illness are, at times, desperate to have a legal option they can more easily access when a loved one is presenting imminent danger; they seek an option that is evenly available and administered across Ohio;
- Any legislation (existing and proposed) should take into consideration the Civil Rights of persons living with severe and persistent mental illness;
- Ohio's mental health system is believed to be underfunded and has a recent history of severe budget cuts as state funds were impacted by the recession;
- There must be adequate funding to support treatment if this legislation is passed and to assure that Outpatient Commitment can be accessed and effectively implemented;
- No legislation will be a sole answer to tragedies that can occur when a person with severe and persistent mental illness presents imminent danger to self and/or others;
- Concerted educational efforts must take place across Ohio's eighty-eight counties to assure even implementation of this proposed legislation, should it become law. Such education did not occur with the existing Court-Ordered Outpatient Treatment law in Ohio.

The Psychiatry and Treatment subcommittee would like to thank all interested parties who provided their input regarding Senate Bill 350. We would like to express our gratitude to Attorney General Mike DeWine and Justice Evelyn Stratton for their ongoing and unrelenting commitment in creating and supporting the work of this Task Force.

Sandra Stephenson, Co-Chair, Psychiatry and Treatment Sub-Committee
 April 2, 2013



Response to Subcommittee on Psychiatry and Treatment

The bill to clarify Ohio's court ordered outpatient treatment law was introduced by Senator Dave Burke (R-Marysville) at the request of the National Alliance on Mental Illness of Ohio in March 2012. The purpose of the bill was to respond to the growing number of instances in which family members sought treatment for a loved one with untreated mental illness and were turned away because the individual was "not dangerous enough" to justify involuntary hospitalization. Family members brought their loved one home and within days they were dead by suicide or as a result of putting themselves in harm's way.

NAMI Ohio believes that for some individuals with untreated mental illness, court ordered outpatient treatment would be an effective alternative to involuntary hospitalization. Unfortunately, many Probate Court judges do not believe that they have the authority to order such treatment because of ambiguities in the law. The bill introduced by Senator Burke attempts to make the law clearer so judges understand that they have the authority to step in before someone with untreated mental illness becomes so dangerous to themselves or others that hospitalization is the only option available.

NAMI Ohio is very grateful to the Attorney General's Criminal Justice and Mental Illness Task Force Subcommittee on Psychiatry and Treatment for undertaking an examination of this bill. During the course of the review by the Subcommittee several organizations and individuals provided valuable input and some offered suggestions for the bill's improvement. NAMI Ohio has reviewed the statements and made three changes as a result. Below is a list of the changes that will appear in a new bill to be introduced by Senators Burke and Charleta Tavares (D-Columbus) early in the 130th General Assembly.

In response to concerns that the proposed new fourth standard in the definition of "Mentally Ill Subject to Hospitalization by Court Order" in 5122.01(B)(4) was too broad, the definition has been changed to read:

~~(4) Would benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person, due to all of the following:~~

(a) the substantial likelihood that, if the person is not treated, the person's current condition will further deteriorate to the point that the person will meet the criteria in (B)(1), (2), or (3);

(b) the person's demonstrated difficulty in adhering to reasonable and appropriate prescribed treatment; and

(c) the likelihood that the person will not voluntarily participate in treatment despite a risk of serious impairment or injury to self or others.

In response to suggestions that information contained in an Advanced Directive should be considered in the development of a treatment plan, the following highlighted section was added to the definition of Treatment Plan in 5122.01(v):

“Treatment plan” means a written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives. The active participation of the patient in establishing the objectives and goals shall be documented. The treatment plan shall be based on patient needs and include services to be provided to the patient while ~~the patient is hospitalized, and after the patient is discharged, or in an outpatient setting.~~ The treatment plan shall address services to be provided ~~upon discharge, and may including~~ but is not limited to: housing, financial, and vocational services; community psychiatric supportive treatment; assertive community treatment; medications; individual or group therapy; peer support services; financial services; housing or supervised living services; alcohol or substance abuse treatment; any other services prescribed to treat the person’s mental illness and to either assist the person in living and functioning in the community or to help prevent a relapse or deterioration. If the person subject to the treatment plan has executed an advanced directive for mental health treatment, the treatment team shall consider any directions included in such advanced directive in developing the treatment plan.

In response to concerns by the Buckeye State Sheriff’s Association that individuals who are subject to court ordered outpatient treatment cannot be placed in jail if they do not follow their plan, the following was added to 5122.15(C).

(C) If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to ~~hospitalization by court order~~, the court shall order the respondent for a period not to exceed ninety days to any of the following:

(1) A hospital operated by the department of mental health if the respondent is committed pursuant to section 5139.08 of the Revised Code;

(2) A nonpublic hospital;

(3) The veterans’ administration or other agency of the United States government;

(4) A board of alcohol, drug addiction, and mental health services or agency the board designates;

(5) Receive private psychiatric or psychological care and treatment;

(6) Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment needs of the respondent. A correctional facility and/or jail for this section of the law is not to be considered a suitable facility.”

In addition to being grateful to the Subcommittee for undergoing a review of the court ordered outpatient treatment legislation, NAMI Ohio is very appreciative to all of those individuals and their respective organizations for taking the time to share their thoughts, concerns and suggestions. We believe that the bill soon to be introduced is much better because of this process.

Task Force on Criminal Justice and Mental Illness

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Melody Parton

**Ohio SB 350 Key Stakeholder Testimonies
Criminal Justice- Mental Illness Task Force
Psychiatry and Treatment Sub- Committee**

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Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

Questions for Key Stakeholders

1. What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)
2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.
3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.
4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.
5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.
6. If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

7. Please discuss any positive or negative ramifications you think SB 350 will have for the following:
 - a. People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;
 - b. Family members of people with SPMI;
 - c. Providers of services and supports for people with SPMI;
 - d. Probate Judges and Courts;
 - e. Law Enforcement Officers;
 - f. Other

What Does the Data Tell Us About Court Ordered Outpatient Treatment?

It Reduces Hospitalizations

- Researchers in 2009 conducted an independent evaluation of New York's court-ordered outpatient treatment law and documented a striking decline in the rate of hospitalization among participants. During a six-month study period, court-ordered outpatient treatment recipients were hospitalized at less than half the rate they were hospitalized in the six months prior to receiving COT. (Source: Swartz et al. 2009, 26-29)

It Reduces Arrests

- A 2010 study found that the odds of arrest in any given month for participants who were currently receiving court-ordered outpatient treatment (COT) were significantly lower than the odds for participants in the non-COT group. The odds of arrest were nearly two thirds lower for participants currently receiving COT, compared with the odds of arrest for the control group. (Source: Gilbert, Allison R., et al, 2010. "Reductions in Arrest Under Assisted Outpatient Treatment in New York." *Psychiatric Services* 61(10):1-4.)

It Reduces Violence

- A 2011 study found that the risk of arrest for a violent offense was 8.61 times greater before court-ordered outpatient treatment than it was while receiving COT. (Source: Link, Bruce G., et al., 2011. "Arrest Outcomes Associated With Outpatient Commitment in New York State." *Psychiatric Services* 62(5):504-08)

It Reduces Homelessness

- In New York, when compared to three years prior to participation in the program, 74 percent fewer court-ordered outpatient treatment recipients experienced homelessness. (Source: New York State Office of Mental Health 2005).

It Saves Money

- A recent study of court-ordered outpatient treatment implemented in the Nevada County, California looked at the cost savings that resulted from 17 individuals who were enrolled in outpatient treatment during the first 2½ years of program implementation (no comparison group was included). The results showed a total cost savings of over \$500,000, attributable to decreases in hospitalizations and in jail time of the 17 individuals. For every \$1.00 invested in court-ordered outpatient treatment in Nevada County, \$1.81 was saved. (Source: Heggarty, Michael 2011. *Assisted Outpatient Treatment: Outcomes Report*. Grass Valley, Calif.: Nevada County Behavioral Health Services)



6/12/2012

Update on NAMI Legislation

After careful consideration both internally and externally through constituent feedback, the Ohio Empowerment Coalition has decided to oppose proposed legislation in SB 350 related to court ordered outpatient treatment. Alternatively however, the Ohio Empowerment Coalition has developed a number of additions or amendments that would clarify the law further making it much more palatable. The OEC feels these additions will increase and strengthen oversight, prevent implementation obstacles or inefficiencies while still acknowledging the unfortunate reality that at times court ordered treatment is necessary.

Our suggestions are four fold:

- 1.) **Mandated treatment alternatives:** Despite providing an elongated list of treatment alternatives, SB 350 made no mention of Psychiatric Advance Directives and how those might be honored when mandating treatment. These directives are meant to prevent individuals from being exposed to medication or treatments that may actually be harmful or act as an obstacle for recovery. **The Ohio Empowerment Coalition would like language in the ORC changes to reflect acknowledgement of psychiatric advance directives as well as a stated commitment to honor them.**

Outside of directives, the OEC still has lingering concerns regarding the types of treatment to be mandated to Peers. During an initial meeting in April of 2012, NAMI Ohio agreed to add peer support to the list of treatment alternatives. The Ohio Empowerment Coalition is incredibly appreciative of NAMI's willingness to positively consider the addition of peer support as well as other recovery oriented programming such as WRAP, BRIDGES and WMR etc. Despite this however, the OEC recognizes that in almost 100% of cases where treatment is mandated, medication compliance will be required. **In an effort to ensure then that we are not solely giving lip-service to recovery, the Ohio Empowerment Coalition would ask that at least one or more of those added recovery oriented services (peer support, supportive housing, WMR, B.R.I.D.G.E.S etc.) outside of therapy or case management be mandated simultaneously alongside medication. Additionally, the OEC would ask further that the "any" option be eliminated from SB 350 in efforts to prevent behavioral healthcare professionals from using this nebulous term as latitude to provide services that may be ineffective or harmful.**

- 2.) **Oversight:** One of the main issues the Ohio Empowerment Coalition's constituents discussed frequently was the lack of identified checks and balances involved in this SB 350. Peers often expressed deep concern regarding the absence of language that also mandated a formal review of the individual's progress and challenges. **The OEC would suggest that a once a month formalized review process occur so that Consumers can renegotiate treatment if they so choose.** This addition may also be helpful for family members as lack of communication with



treatment providers was mentioned repetitively and with frustration throughout NAMI's annual 2012 conference.

Further, although treatment teams typically have weekly transdisciplinary care meetings, the OEC would like discover which venues can be pursued for an individual if he/she would like to change treatment course. Individuals who choose to take medication as a part of their recovery are more likely to continue over time when they find that the side effects are manageable. **As professionals in the mental health/recovery arena know, treatment needs evolve. The Ohio Empowerment Coalition seeks assurance that treatment teams and medication alternatives can evolve as well.**

To aid in that process, The OEC would also suggest inclusion of an Ombudsman program. With additional training in mental health, existing individuals from the Ombudsman program in the Ohio Department of Aging could initially absorb this responsibility while the Ohio Empowerment Coalition works to develop Peer Specialist training which emphasizes the role of a Peer Advocate. Individuals being mandated to treatment have already lost certain rights. Their ability to advocate is compromised. The OEC recommends that an Ombudsman be available to the Peer within 48 hours of the court's decision or in the event they are requested by the Consumer. This program would work similarly to what is already in place in long term care programs. Ombudsmen are not employed by provider organizations, emphasize person centered care and therefore will have no conflict of interest when advocating on behalf of the Peer.

Looking long term, although early research implied that court ordered outpatient treatment lowers hospital bed days and reduces recidivism in the criminal justice system, these findings are correlational. Definitive evidence has yet to be presented that shows it is in fact the court order, rather than increased and expedient access to treatment that actually yields results. If it is increased access to services that produces outcomes, this law would be proven ineffective in achieving the outcomes it purports. **The OEC would strongly advocate that NAMI make a commitment within SB 350 outline a plan for future review of outcomes.**

- 3.) **Implementation:** The goal of SB 350 is to achieve quick intensive access to mental health treatment for individuals who are acutely a danger to themselves or someone else. If the infrastructure providing treatment is ill equipped to cope with this change, Peers will not receive effective care and the very tragedies NAMI Ohio hopes to prevent may continue. **Although NAMI Ohio stated behavioral health agencies are prepared to absorb mandated individuals, the Ohio Empowerment Coalition continues to be concerned.**

Individuals who decompensate are more likely than not disconnected from treatment and/or recovery programming. Consequently, it is likely individuals will need to establish new services with a mental healthcare provider. It is inevitable that front loading will occur. Although some organizations may say they are ready to handle an influx of new cases, the OEC wonders if



NAMI has canvassed areas across the state, specifically smaller rural portions where behavioral health care organizations are at capacity.

Alternatively, although Peers may be pushed to the front of the line during the time in which they are mandated to receive care but after it ends, will the individual go back to a wait list? **Without proper implementation, this legislation may serve to be yet another stopgap measure which does nothing to break the chaotic and cyclical nature individuals' experience during decompensation.** Beyond this issue, NAMI has yet to acknowledge or comment regarding the existence of a plan for the individuals already in recovery whose treatment/care is interrupted due to the introduction of new time sensitive caseloads. **The Ohio Empowerment Coalition would suggest that NAMI reach out to other states that have already enacted similar legislation to better understand and help outline how provider organizations can cope with new Consumers while still providing ethical, evidence based practice.**

Finally, outside of staffing concerns there is the issue of funding. This has been virtually ignored throughout any publication surrounding the proposed legislation. Private insurance only goes so far. Further, even despite having insurance, individuals may be unable to pay the high co pays that often accompany mental health care treatment. Alternatively, applying for and receiving approval for Medicaid/SSDI is incredibly complex, time consuming and often slow moving. Because there will be a time frame attached to the mandate, who will provide funding or coverage while individuals/families scramble to procure a payer? Will behavioral healthcare providers become beholden to courts to provide free care at will? **The Ohio Empowerment Coalition strongly advises legislators to discover what revenue exists in order to aid with implementation of SB 350.**

- 4.) **Education/Outreach:** Although NAMI Ohio believes changing the ORC will add teeth to the existing law, education and outreach will still be necessary. Mental health care and mental illnesses are incredibly complex. Consumers, family members and advocates have a unique understanding of what coping and recovery can include and look like. **As a statewide advocacy organization, the Ohio Empowerment Coalition would like to collaborate with NAMI Ohio to ensure the judicial system is adequately educated surrounding the opportunities and limitations of SB 350 in helping Consumers.**

Terry Russell, Executive Director
National Alliance on Mental Illness of Ohio
Statement on S.B. 350
Before the
Attorney General's Task Force on Mental Illness and Criminal Justice's
Subcommittee on Psychiatry and Treatment
November 7, 2012

Thank you for the opportunity to speak with you today about a bill that is extremely important to the members of the National Alliance on Mental Illness of Ohio. More importantly, thank you for spending two full days listening to the views of a variety of organizations and individuals with an interest in court ordered outpatient treatment. The fact that you are doing this demonstrates the significance of this issue to Ohioans impacted by mental illness.

By way of background, NAMI Ohio is the statewide association that serves as the voice on mental illness in Ohio. Our mission is "to improve the quality of life, ensure dignity and respect for persons with serious mental illness, and to support their families."

NAMI Ohio is comprised of thousands of individuals with mental illness, family members, advocates and professionals working together to ensure that Ohioans with mental illness and their loved ones receive the treatment and support they need. NAMI Ohio and our 52 local affiliates provide an array of programs to communities throughout the state to support individuals with mental illness and their families and to eliminate the stigma of mental illness. In addition, NAMI Ohio has a rich tradition of working with the Governor and members of the General Assembly through our education and advocacy efforts.

NAMI Ohio understands that untreated mental illness destroys individuals and families and imposes high costs on state and local government. Many people left untreated

see their mental illness worsen. Children with untreated mental health disorders are often unable to learn or participate in a normal school environment. Adults lose their ability to work, and many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay millions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, lost parent rights, law enforcement, and incarceration. Not only does a lack of adequate mental health care hurt our economy, it exacts enormous human suffering on our families and destroys lives.

Allow me to provide some background on NAMI Ohio's involvement in S.B. 350. About a year and half ago, one of our affiliates -- NAMI Franklin County -- approached us with a request for assistance in getting Ohio's law changed. The problem was this....several of their members were losing loved ones to untreated mental illness. When the families asked for help, they were told to go away and come back when their loved one was either suicidal or homicidal. Only then would help be available. Unfortunately, for several of these families, that turned out to be too late. Their loved ones either took their own lives or put themselves in a situation where it was taken from them.

As we reviewed Ohio's law and spoke with several experts we discovered that when it comes to court ordered treatment, there are differing interpretations. And it doesn't take an expert to understand why. Even to a lay person, it is easy to see why judges may be confused. To lend clarity to the law, we identified four changes. We took these changes to Senator Dave Burke and he offered to introduce a bill on our behalf.

The first, and most notable area of confusion can be found in Section 5122.15 (C) of the Ohio Revised Code (see page 113 of the bill) where it states: "If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is

a mentally ill person subject to hospitalization by court order, the court shall order the respondent for a period of not to exceed ninety days to any of the following...” and then it goes on to list the options available to the judge. Then, in section (E) the statute directs the judge, “in determining the place to which, or the person with whom, the respondent is to be committed, the court shall consider the diagnosis, prognosis, preferences of the respondent and the projected treatment plan and shall order the implementation of the least restrictive alternative available and consistent with treatment goals.”

As a result of this ambiguity, only a handful of probate court judges in Ohio understand that court-ordered outpatient treatment is within their purview. To eliminate any confusion, we recommend changing the term “mentally ill person subject to hospitalization by court order” to read “mentally ill person subject to court order”.

In addition to eliminating confusion, we believe this clarification has the potential to save dollars that otherwise would be spent on costly hospitalizations.

The second area of confusion in current law, and one that stands in the way of families seeking help for their loved one is in the fourth criteria listed in Section 5122.01 in the definition of “mentally ill person subject to hospitalization by court order.” (Starting on the bottom of page 90.) Currently, the law states that a person meets this definition if they “Would benefit from treatment in a hospital for the person’s mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk of substantial rights of others or the person.”

The problem is no one knows what that means.

The first three criteria are fairly straightforward. The first one states that the person must represent “a substantial risk of physical harm to self...” The second one states that the person must represent “a substantial risk of physical harm to others...” And the third one states, that the person must represent “a substantial and immediate risk of serious physical impairment or injury”.

We believe that the fourth criteria should be equally straightforward. For this reason, we propose the following:

The person would benefit from treatment due to all of the following:

- a) The person is unlikely to voluntarily participate in treatment.
- b) The person has demonstrated difficulty in adhering to prescribed treatment.
- c) The likelihood that, if the person is not treated, the person’s current condition will deteriorate to the point that the person will meet the criterion” in one, two or three above.

The goal here, of course, is to keep our loved one with untreated mental illness from becoming so ill that they are ready to hurt themselves or someone else.

There are two additional changes in the bill that will provide clarity to Ohio law.

In section 5122.01 (V) we define what a treatment plan in an outpatient setting may include as there is no delineation of it elsewhere in the ORC. You’ll find this addition on page 96 of the bill.

Finally, in Section 5122.111, we insert a copy of the state’s exiting Affidavit of Mental Illness form into the ORC (bottom of page 103) and in Section 5122.13 we clarify that

the form should be filed with the Probate Court (page 107). We did this because we were hearing from our members that they didn't know where to find a copy of the form or where to file it. When a family is in crisis, it can be very frustrating not to have ready access to the information you need. We believe this will help.

With these changes in the statute, we believe there will no longer be any question about whether a probate court judge has the authority to order certain individuals with serious and persistent mental illness into outpatient treatment. If used correctly, these changes will allow a judge to step in before someone with a serious mental illness who is unaware of his or her need for treatment becomes so ill that hospitalization or incarceration are the only options remaining. Lack of awareness of illness - a neurological syndrome called anosognosia - is believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not follow through with treatment. In many cases, such individuals can be persuaded with a court order to follow their treatment plan. This is commonly referred to as the "black robe effect."

Court ordered outpatient treatment is not the answer for everyone who meets the criteria, but for some it could mean the difference between life and death. This bill simply removes any question on the part of judges that they have a tool available to use when there is clear and convincing evidence that without treatment, the individual will likely become a substantial risk of physical harm to him or herself or others and end up in the hospital, jail, or worse...dead.

Some opponents have suggested that S.B. 350 will result in more expense to Ohio's mental health system. We disagree. The vast majority of individuals who would meet court ordered outpatient treatment criteria are already receiving costly and inefficient service. Not only are they cycling in and out of emergency rooms and state hospitals,

they are often frequent users of Ohio's jails and prisons. I have attached a list that summarizes several studies from other states that demonstrate that court ordered outpatient treatment actually resulted in cost savings from reductions in hospitalizations, arrest rates and homelessness. While we do acknowledge that there may be additional costs to the court system as a result of S.B. 350 we believe the savings will offset those costs.

It is important to note that no new programs or services would be required under this proposal. It simply means that many individuals who are currently cycling in and out of emergency rooms, state hospitals, jails, and prisons would have access to existing community mental health treatment services that they now cannot access because the severity of their illness often precludes their awareness of and need for treatment. This proposal would put an end to the revolving door and put individuals with severe and persistent mental illness on a path to recovery.

There *is* truth to the argument that use of court ordered outpatient treatment forces the system to triage mental health clients so that those who are most ill would receive services first and others may have to wait longer to gain access care. Unfortunately, turning individuals in need of mental health services away has been a sad reality of our grossly underfunded system for years. At least S.B. 350 provides a mechanism to help ensure that those who need care the most can receive it.

You may also hear opponents argue that S.B. 350 has the potential to violate an individual's rights. S.B. 350 does nothing to change current law which ensures that all individuals are afforded full due process rights, including having the right to legal counsel. If they cannot afford a lawyer, the court will appoint one. They also have the right to an independent expert mental evaluation, regardless of ability to pay.

Finally, I want to put to rest rumors that someone could be “forced” to take medications under S.B. 350. That is simply not true. S.B. 350 provides for coordination and access to medication as a component of the treatment plan, but no one will be forced to take medication against their will. There is a separate provision in current law that dictates how and when medication can be administered over a person’s objection. If someone refuses to follow their treatment plan, the worst that could happen is that they would continue to decompensate and ultimately be ordered into the hospital.

Without passage of S.B. 350, many individuals and their loved ones will continue to suffer the anguish of untreated mental illness. At the same time, Ohio’s emergency rooms, hospitals, jails and prisons will continue to provide expensive care to many who otherwise could be successfully treated in a less expensive and more efficient outpatient setting. Most importantly, we believe S.B. 350 will save lives.

Again, thank you for the opportunity to share NAMI Ohio’s position with you. I am happy to answer any questions.

dmalawista@ci.athens

Terry Russell – NAMI Ohio

Questions:

What is the difference between forced medication and following a Treatment Plan?

Again, this bill does not speak to forcing medication at all and when a person has a treatment plan today in an outpatient setting. Sandy would know better than me that to force medication as matter fact I don't think is a practice. To force medication is very very specific in current law and really responds to those in State Hospitals in behavior or the criminal justice system to. That's where that's forced but in this bill that does not bring that issue to that level.

Should this bill pass, how would you get the information out to all 88 Counties and to get it enforced?

First of all, there would be training to all Probate Judges around the passage of this bill. NAMI Ohio would be assured of that, but we also have 52 affiliates that we would have out in each Probate Court talking to the Judges helping them to find the treatment. The other thing is the treatment system would immediately have to get together and talk about the triage that I mentioned in our testimony.

Betsy Johnson – NAMI Ohio

I just want to elaborate on the previous question about forced medication, in current law under the language in the bill for treatment plan. It requires the active participation of the patient and establishing the objectives and goals of the treatment plan, so somebody is opposed to taking medication presumably the treatment team will take that into account as they are developing the plan.

Terry Russell – NAMI Ohio

I also want to add to that issue because as I said the rumors are it's also a way for opponents to emphasize their opposition to something and to add something that's not there. Wwhat I asked during all this dialogue is we are very open to each other we listen to each other I think there are some things here that should be questioned but at the end of the day we need to save the people out there that are on the streets today because of untreated mental illness.



August 13, 2012

Executive Committee

The Honorable Dave Burke
Ohio Senate
Statehouse
Columbus, Ohio 43215

Lisa M. Griffin
President

Dear Senator Burke,

Jennifer Viering
Vice-President

Thank you for introducing S.B.350 to clarify the law on court ordered outpatient treatment. Our organization, Ohio Center for Advocacy, Training & Support, Inc. (OCATS), support the bill because we believe that it may prevent some individuals with serious mental health challenges from winding up in jail, prison, a psychiatric hospital, or in a worst case scenario dead.

Karen Curlis L.S.W.
Treasurer

Michael Moon
Parliamentarian

By way of background, OCATS is the grassroots statewide organization created in 2008 out of the demise of The Ohio Advocates for Mental Health. Our mission is to promote the mental health of Ohioans by encouraging growth, independence and recovery through advocacy, training, support, and coordination of state and local consumer recovery efforts.

Board Members

Robert Pickard

OCATS believes there are some individuals with serious mental health challenges who are in denial and fail to recognize their need for treatment. These difficulties put them at risk for hurting themselves or others when they're in crisis. Several members of our organization have experienced this situation personally or know someone who has. For instance....

"I know I would rather lose some of my personal freedom than to lose a foot to frost bite in the winter one day when I don't know enough to come in from the cold during an episode or crisis." Anonymous

One of OCATS Board Members had been taken to jail. He was vocal about his mental illness and his need for medications. At the jail he went 4 days without his medications. During lock down he began ramming his head against the door in effort to get his medications. For that behavior he was sent to the "hole." The next day a lawyer came to see him and the medications were started immediately.

Due to the nature of the case, he was sent to Youngstown to testify. Then he was sent to court and was put on court ordered outpatient treatment. He has been living in the community successfully since that time with mental health treatment and the support of his closet peers. – Michael Moon

We will no longer tolerate and turn our backs on minority young males who are ending up in our penal institutions instead of getting the treatment they need.

Without S.B. 350 many individuals and their loved ones will continue to suffer the anguish of an untreated illness. At the same time, Ohio's emergency rooms, state hospitals, jails, and the institution which holds most of those with a mental health challenge, the prisons, will continue to provide expensive care to those who otherwise could have been successfully treated in a less restrictive and less expensive outpatient setting. As such, OCATS views S.B.350 as a tool for recovery. S.B.350 does not proclaim to have the answer for everyone, but for some it could mean the difference between a life chosen and a life taken away.

Thank you for your support!

Sincerely,



Lisa Marie Griffin
OCATS Executive Board President
(330)289-1466

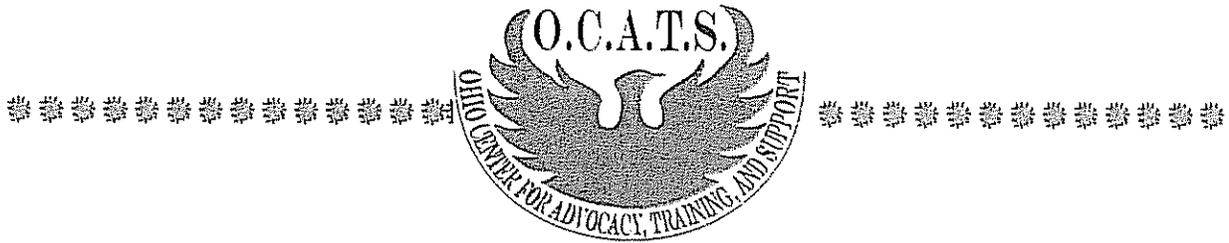
cc: Terry Russell, NAMI OHIO

OHIO CENTER FOR ADVOCACY, TRAINING, AND SUPPORT
P.O. Box 36 Tallmadge, Ohio
44278 • www.ocats.org

.....
ADVOCACY



SUPPORT
.....



Mission Statement

The mission of the Ohio Center for Advocacy, Training and Support is to promote the mental health of Ohioans by encouraging growth, independence and recovery through advocacy, training, support and the coordination of state and local consumer recovery efforts.



Values Statement

All of the Ohio Center for Advocacy, Training and Support's endeavors will be guided by its core values: hope, empowerment, integrity, independence and recovery, with respect for all people and inclusion of all differences.

Typed copy of handwritten testimony (see original pages 21-25)

Lisa Marie Griffin – President (O.C.A.T.S.) – The Ohio Center for Advocacy Training and Support Inc.

My name is Lisa Marie Griffin; I currently serve as president of the Board of Trustees.

O.C.A.T.S. role as a key stakeholder with interest in Senate Bill 350, court ordered outpatient treatment

(1) To advocate and support, for the State of Ohio mental Health Consumers in the Judicial System.

(A) By encouraging growth, independence and recovery;

(B) Through advocacy, Training, Support and the coordination of State and local consumer recovery efforts.

(2) Advocate for mental health consumers' utilization of alternative resources to incarceration, that Ohioans receive quality mental health. Especially should they find themselves in a position, they're in need for treatment.

(3) As a grassroots statewide self-help advocacy organization which arose from the demise of the past statewide advocacy organization, we believe in the safety of those Ohioans who may be too ill to understand their need for treatment. Without this vital bill's passage we may find more of our own peers incarcerated while our jails are already taking place of the care hospitals once took, hospitalize or even dead needlessly.

(4) O.C.A.T.S. position on the existing law on court-ordered outpatient treatment it is under-utilized by court personnel and a little known resource by the defense and the family of the defense. The existing law has a high success rate in treatment completion.

(5) O.C.A.T.S. believes Senate Bill 350 is needed because some individuals with serious mental health challenges who are in denial and fail to recognize their need for treatment. These difficulties put them at risk for hurting themselves or others when they're in crisis. Senate Bill 350 is needed because we can no longer tolerate or turn our backs on minority young males who are ending up in the penal institutions instead of getting the treatment they need.

There was a Court Ordered Outpatient Treatment case in Summit County back in August 2012. The Consumer was ordered into court ordered treatment where his sister, who was also the consumer's victim while he was in crisis, also received treatment services. Due to a "No Contact Order" by the Municipal Judge the sister was denied her Treatment Services at that organization and had to go elsewhere for mental health treatment.

O.C.A.T.S. believes Senate Bill 350 is used effectively but does need to examine the effects of dual treatment in a family setting.

(6) When both family members, the victim and the consumer are receiving services from the same treatment facility and separated by Protection Order or a No Contact Order, special circumstances should be allowed for common treatment situations, if the victim is denied services due to the Court Order.

(7) (A) SPMI living in the communities and as discharged from psychiatric hospitals to community position ramifications O.C.A.T.S. feels Senate Bill 350 are (1)a consumer has a mental health structure and support. (2) Alternative to incarcerations, hospitalizations, and needless deaths. (B) Family members will have a feeling of community support and less feelings of isolation for community resources and family bonding. (C) Provide services to the SPMI that may not have received the treatment needed without Senate Bill 350 while in crisis. (D) Provides Judges and courts resources in lieu of incarceration or hospitalizations. Less Stress on the Courts; Low return to Courts and more personal communication with family, treatment providers and support team. (E) Less untreated consumers to handle on a daily basis. Community Safety for Law Enforcement.

(8) I was once court ordered into court ordered treatment and it returned my life back to me as I always know it could be as well as maintaining a healthy relationship with my family and community.

Lisa Marie Griffin – Ohio Center for Advocacy Training Support Inc.

No Questions Asked

11-6-12

Lisa Marie Griffin is my name. The grassroots statewide advocacy organization known as The Ohio Center for Advocacy Training and Support - Inc. (OCATS). I currently serve as President of the Board of Trustees.

OCATS role as a key stakeholder with interest in HB 350, Court-ordered Outpatient Treatment (1) TO ADVOCATE AND SUPPORT, FOR THE STATE OF OHIO MENTAL HEALTH CONSUMERS IN THE JUDICIAL SYSTEM,

(A) By encouraging growth, independence and recovery.

(B) Through Advocacy, Training, Support and the coordination of State and local consumer Recovery Efforts.

Advocate for mental health consumers utilization of alternative resources to incarceration, that Ohioans receive quality mental health. Especially should they find themselves in a position, their in need for treatment.

4. Provides judges and courts
resources in lieu of incarceration
hospitalizations.

Less stress on the courts

Low Return to courts

More Personal Communication with
FAMILY, TREATMENT PROVIDERS AND SUPPORT TEAM

5) Less Untreated consumers to
handle on a daily basis.

Community Safety for Law Enforcement

6) I was once court ordered into
court toward treatment and it

returned my life back to me
as I always know it could
be as well as maintaining a
healthy relationship with my
family and community.

Lisa Marie Diplina
OCASTS President

in some, the victims and the consumer are receiving services from the same treatment facility and separated by Protection Order or a No Contact Order, special circumstances should be to allowed for common treatment situations, if the victim is denied services due to the Court Order.

- (A) SB350 will support the community and reduce the stigma from psychiatric hospitals to community based organizations
- OCATS feels SB350 are (1) a consumer has mental health structure and support.
- (2) alternative to incarcerations hospitalizations and medical deaths.
- (B) Family members will have a feeling of community support, and less feelings of isolation for community resources + Family bonding.
- (C) Provide services to the SPMTI that may not have received the treatment needed without SB350 while in crisis.

need for treatment. These difficulties put them at risk for hurting themselves or others when they're in crisis. SB 350 is needed because we can no longer tolerate or turn our backs on minority young males who are ending up in our penal institutions instead of getting the treatment they need.

There was a Court Ordered outpatient treatment case in Summit to look in upon the consumer was ordered into court a dual treatment where his sister, who was also the consumer's victim while he was in crisis, also received treatment services. Due to a "No Contact Order" by the Municipal judge the sister was denied her treatment services at that organization and had to go elsewhere for mental health treatment.

JCASS believes SB 350 is used effectively but does need to examine the effects of dual treatment in a family setting. When both family

(3) As a grassroots statewide self-help advocacy organization which arose from the demise of the past statewide advocacy organizations, we believe in the safety of those Ohioans who may be too ill to understand their need for treatment. Without this vital bill's passage we may find more of our peers incarcerated while our jails are already taking place of the care hospitals can't take, hospitals or even dial needlessly.

(4) - OCA's position on the existing law on court-ordered outpatient treatment it is under utilization by court personnel and a little known resource by the defense and the family of the defense. The existing law has a high success rate in treatment completion. (2) OCA's believes SB 350 is needed because some individuals with serious mental health challenges who are in denial and fail to recognize their

DISABILITY RIGHTS OHIO

Ohio Disability Rights Law and Policy Center, Inc.

November 7, 2012

Disability Rights Ohio's Responses to the Criminal Justice / Mental Illness Task Force, Psychiatry and Treatment Sub-Committee Questionnaire on SB 350

1. What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)

Michael Kirkman, Executive Director of the Ohio Disability Rights Law & Policy Center, Inc. "Disability Rights Ohio" (formerly known as Ohio Legal Rights Service) is designated under federal law to protect and advocate for the rights of people with disabilities in this state. This includes individuals who are identified as psychiatrically disabled and interact with the states mental health system. As the "P&A" system, Disability Rights Ohio's mission is to advocate for the human, civil, and legal rights of people with disabilities in Ohio.

2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.

As the P&A in the state of Ohio, Disability Rights Ohio advocates on behalf of people with disabilities, including the rights of individuals with mental illness to have a voice in their own mental health care and recovery. Disability Rights Ohio participates on the Criminal Justice & Mental Illness Task Force and our lawyers have provided legal representation to clients in civil commitment and related cases in hundreds of cases over the years.¹

3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.

¹ Representative cases include: *Steele v. Hamilton County Community Mental Health Board*, 90 Ohio St. 3d 176, 736 N.E.2d 10 (2000) cert. denied 532 U.S. 929 (2001)(amicus—court ordered medication of involuntary committees); *Heller v. Doe by Doe*, 509 U.S. 312 (1993)(amicus—counsel for organizations of people with disabilities—equal protection, involuntary commitment of people with mental retardation); *State ex rel. Ohio Legal Rights Service v. Belskis*, 85 Ohio App. 3d 59, 619 N.E. 2d 77 (Franklin Co. 1993)(jurisdiction of probate court to order involuntary electroconvulsive therapy); *In re Miller*, 63 Ohio St. 3d 99, 585 N.E. 2d 396 (1992)(amicus—applicability of physician patient privilege in involuntary commitment; due process); *Cleveland v. Ohio Department of Mental Health*, 84 Ohio App. 3d 769, 618 N.E. 2d 244 (Franklin Co. 1992)(due process challenge to involuntary medication of patients by state hospitals); *In re Boggs*, 50 Ohio St. 3d 217, 553 N.E. 2d 676 (1990)(due process in involuntary commitment); *In re Guardianship of Allen*, 50 Ohio St. 3d 142, 552 N.E. 2d 934 (1990)(amicus—right to counsel in guardianship); *In re Milton*, 29 Ohio St. 3d 20, 505 N.E. 2d 255 cert. denied 484 U.S. 220 (1987)(involuntary treatment of patient who is competent; First Amendment religious exercise).

Disability Rights Ohio and the clients it represents have strong concerns with SB 350.

*Involuntary hospitalization has been found by both the Ohio and United States Supreme Court to be a significant deprivation of liberty by the state, one that is only slightly less intrusive of constitutionally protected interests than confining a person to jail. Involuntary confinement also raises the potential of nonconsensual medical treatment, an area where the courts have also recognized a significant privacy interest that is also protected by the U.S. and Ohio Constitutions. The rights provisions of Chapter 5122 of the Revised Code reflect the legislature's strong belief in the constitutional protections called for by the courts. Given the extraordinary nature of the state's power in this situation, it is not surprising that the question of how the power is invoked has been the subject of litigation. For example, in the case of *In re Miller*, [63 Ohio State 3d 99 (1992)], a case that was litigated by the Legal Rights Service almost 20 years ago, the Ohio Supreme Court found that the written statement given to a hospital when a person is taken into custody is a mandatory component for the initiation of an emergency commitment. The statement ensures the existence of probable cause to support the involuntary commitment of a person who may be mentally ill and in need of court-ordered hospitalization. Similarly, in another case in which LRS represented the respondent, *In Re Mental Illness of Boggs*, [50 Ohio St. 3d 217 (1990)], the Ohio Supreme Court reversed a civil commitment order because the factual allegations in the affidavit did not support a finding that there was probable cause to believe the appellant was a mentally ill person subject to hospitalization by court order. These decisions direct that invoking the authority of the state to detain a person with a mental disability against his or her will must begin with a written statement demonstrating the existence of probable cause to support the involuntary confinement.*

*In addition, mental health professionals, agencies and courts have significant legal tools at their disposal to warn or act should a patient present a danger to self or others. The decision in *Estate of Morgan v Fairfield Family Counseling Center*, [77 Ohio St. 3d, 673 N.E.2d 1311 (1997)], established in Ohio a duty for a therapist to protect third persons, following the California decision in *Tarasoff v. Regents of the University of California* [17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976)]. The General Assembly responded quickly to the decision by amending state law [RC § 5122.34 and §2305.51] to set out immunity from suit for a professional who participates in the commitment process, and to define steps that must be used by reasonable professional to comply with the Morgan duty.*

The proposed changes legislation appears to be unnecessary as court-ordered outpatient treatment is already authorized and in fact the default situation in current law. Commitment is to the local board or a designated agency, not specifically to a treatment venue or hospital as was the case prior to 1989. The board or agency determines the appropriate treatment plan and location of treatment, which can and often does involve outpatient treatment. While some county probate judges choose to be more engaged in this process than others, the law plainly allows for such involvement, and it is our understanding that the Ohio Judicial Conference has provided a letter to the sponsor of the bill affirming this point.

SB 350 goes far beyond being what the proponents of the bill characterize as a mere "clarification" of the law. Rather, the bill would amend and expand the legal standard used in determining when an individual could be found to be mentally ill and subsequently ordered by a

court to enter outpatient treatment. It does so with a remarkable lack of clarity, raising concerns about how judges would apply the terms of the standard uniformly and consistently across 88 counties.

SB 350 would increase the demand for services on an already stressed community mental health system and court structure without providing any additional resources to support such demand.

Finally, after a review of scholarly articles and literature on the subject, there does not appear to be any compelling evidence to support the proposition that court-ordered outpatient treatment alone is effective. Rather, what has been found to be beneficial in jurisdictions that implemented court-ordered outpatient treatment was increased funding to expand availability of resources supporting consistent and accessible community mental health services. Outreach to and assertive case management with affected populations similarly increased compliance and reduced recidivism.

4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.

The current law strikes a careful balance between an individual's constitutional rights to liberty and bodily integrity against the public's health and welfare interests, and does not need to be altered. This question is one that has been repeatedly litigated in the courts, and the courts have strongly emphasized the need for reserve and thoughtful process in imposing confinement and involuntary treatment on individuals with disabilities.

5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.

SB 350 as currently drafted is unnecessary. If the proponents of the bill seek to clarify and highlight that court-ordered outpatient treatment is an authorized option under current law, perhaps they should consider a non-legislative strategy. For example they could support increased continuing legal education initiatives addressing the issue of civil commitment, psychiatric disabilities, and related matters. We recommend that stakeholders begin a comprehensive discussion and examination on of what alternative policies and funding opportunities we could all support to improve Ohio's community mental health system and support the individuals in need of such services.

6. If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.

N/A

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

The proposed language in SB 350 that amends Revised Code section 5122.01(B)(4) should be removed. The bill would unjustifiably amend and expand the legal standard for determining when an individual is mentally ill and can be ordered committed to a hospital or to outpatient treatment. Matters of such importance that seek to balance the rights of individual's liberty and privacy interests against the public's health and welfare interests are not mere clarifications. In any event, we recommend the bill include a provision appropriating additional funding to the community mental health system.

7. Please discuss any positive or negative ramifications you think SB 350 will have for the following:

a. People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;

SB 350 would unnecessarily expand the legal standards for determining whether an individual is mentally ill and subject to hospitalization or court-ordered outpatient treatment. Accordingly, other individuals with SPMI may struggle to access community mental health services if courts order more people into outpatient treatment.

b. Family members of people with SPMI;

Families are the "first responders" for people with psychiatric disabilities, providing care and support when their loved ones struggle with lack of affordable housing, appropriate job training and support, and access to appropriate services. This bill, however, does nothing to address those issues. Instead, it may actually create more problems for an already strained system. The bill is part of a historic tendency to treat the person as "in need" rather than able to manage their own recovery, which is what has resulted in the greatest successes for individuals and their families.

c. Providers of services and supports for people with SPMI;

N/A

d. Probate Judges and Courts;

We understand the Ohio Judicial Conference is on record opposing SB 350. In our view, the bill could increase the demand for involuntary commitment hearings, thereby adding further stress on the dockets of the Probate Judges and the court system.

e. Law Enforcement Officers;

N/A

f. Other

8. Is there any additional information that you would like to share with us regarding your position on SB 350?

Please see the attached Frequently Asked Questions (FAQ) document that Disability Rights Ohio prepared to educate and inform consumers, stakeholders and other interested parties on SB 350.

DISABILITY RIGHTS OHIO

FREQUENTLY ASKED QUESTIONS: Senate Bill 350 – Expansion of civil commitment and outpatient treatment for persons with mental illness

What is it?

S.B. 350 proposes to expand the current standard in Ohio law for determining whether a person with mental illness requires court-imposed involuntary commitment, and expressly includes the option for courts to order assisted outpatient treatment.

What is the current law?

A court can order involuntary hospitalization or psychiatric or psychological care and treatment for an individual with mental illness if the individual meets any one of the following criteria: (1) is a danger to himself; (2) is a danger to others; (3) is unable to provide for basic physical needs; or (4) would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of himself or others. To meet the fourth standard, Ohio courts have adopted a test that weights the totality of the circumstances.

What does S.B. 350 propose to change?

S.B. 350 would change the language of the fourth criteria (would benefit from treatment) and instead require a finding of all of the following: (1) unlikely to voluntarily participate in treatment; (2) has demonstrated difficulty in adhering to the treatment; and (3) the likelihood that, if the person is not treated, the person's current condition will deteriorate to the point that the person will meet the criterion to be a danger to himself, others, or unable to provide basic needs. The bill would also include express statutory option for courts to provide assisted outpatient treatment.

What are our concerns with S.B. 350?

- It would expand the definition of individuals who could be subject to court intervention and involuntary commitment;
- Courts can already order hospitalization and outpatient treatment under Ohio's current involuntary commitment law;
- The mental health system is already in tremendous need of resources and system reforms. The bill would create an additional demand for these limited resources without providing additional funding;
- Studies have shown that without an accompanying injection of resources to support additional community services, there is little to no benefit from court-ordered involuntary outpatient treatment alone. *RAND Study: "The Effectiveness of Involuntary Outpatient Treatment."*;
- The bill would unjustifiably alter the constitutional balance of an individual's liberty and privacy interests against the public's health and welfare interests;
- The bill's proposal to amend the legal standard for determining mental illness, conflicts with the current "totality of the circumstances" test, which gives courts discretion in weighing all relevant factors.
 - Since it would no longer consider whether a person has awareness of his condition and instead focuses on whether the person agrees with a specific treatment, a person could meet the criteria if he is fully aware of his condition but disagrees with a prescribed treatment.
 - Criterion 1 and 2 could easily be conflated because a demonstrated difficulty in adhering to treatment would almost necessarily require a finding that the person is unable to understand the need for treatment.
 - The likelihood that the person's condition will deteriorate in the future shifts the focus from the person's present and past condition to speculation on future events.

Michael Kirkman – Ohio Disability Rights Law and Policy Center (previously OLRS) Disability Rights Ohio

Questions:

What part of Senate Bill 350 is ambiguous specifically how would you clarify ambiguity?

The definitional standard the three prongs there and I don't have the actual language in front of me difficulty in adhering to the treatment. I don't know what that means. What does difficulty mean? Does that mean you took your meds one day but you didn't take them the next day? It's a very ambiguous standard and the likelihood that if the person is not treated their condition will deteriorate to the point, meet the criteria to be a danger to himself. Again, that doesn't provide any benchmarks or any kind of real guidance for a Judge as to what deteriorate means and I think its very subjective standard. One that could be subject to many different interpretations and from different perspectives. We have often talked with family members or people who have disabilities who have completely different perspectives on where they are in their lives or what treatment should be sought or what activity should be sought. So if you plug that into a legal standard that allows a court to order someone into treatment, those subjective determinations take on real meaning and real force in the person's life and it's not a very clear standard.

I don't think there's anything with the current standard, so I think you start with that and you work with that. You let the Judges implement that as I mentioned Courts have struggled with before because it was a compromise when it passed. It was actually a compromise because people were concerned the original version wasn't going to be constitutional so it has some language in there that requires the Court to do a little heavy lifting that's been before the Courts of Appeal several times. So even as the Courts have worked through that through experience and history now adding a new standard like this has got all of these and oriented subjective types of standards would be very difficult. So our position is we don't need to change it.

Is it your recommendation that the current law need no clarification at this time? If so how would you suggest families get the help they need to help keep their loved ones alive?

We have covered a lot of this, our recommendation is that the law does not need to change in order to accomplish outpatient commitment. The system needs to get better it needs to be better funded it needs to be more accessible. The data actually shows that what works about court ordered treatment is the richness of the services that are provided to the person that there's no ability to factor out of the court ordered treatment studies the fact that the services that are provided to the person become richer once you have a court order. We have seen in other studies going back into the 70's if you do aggressive case management if you do outreach for example if you send case managers out to the person instead of making the person come downtown for services the recidivisms the compliance goes up. Those studies have been around since the mid 70's so it's not rocket science we have researched the notion that if the systems is there and its adequate and accessible most people almost everyone will voluntarily participate in the system. If you have a system that supports jobs with adequate housing it

gives people what they need in order to enter into recovery these questions will come up in a very small number of cases.

Dwayne Maynard has a question about clarification specifically – this is Michael Kirkmans response “I don’t know what that would be without more dialogue and that’s fine we can have that dialogue later. It’s very clear that the person is committed to the board and the board develops a treatment plan and decides the treatment. In some cases that would involve outpatient treatment and many cases that would involve hospitalization for acute condition and gradually discharged and some supervision in the community for a brief period of time. It also provides for a closure on that which still has the same mechanism in this bill so that’s really what this bill does is expand the definition in such significant way so that its begins to capture people who are not traditionally subject to the involuntary orders. We know that will help some people and they will get better services as a result of a court order but we do not know who it will miss or the impact it will have on the system for other people who are already being turned away an told they have to wait six months two months for a prescription or for Medicaid services and those are really critical service issues.

How are the rights of the individual with a severe brain disorder protected when their lack of insight into their illness results in incarceration or worse death?

Well we don’t incarcerate and we have worked vigorously to keep people out of the jail services to get services when there in the jail system so I just want to put that out there. But that’s a wrong question the narrative is the wrong narrative because that presumes that this bill will change that and it won’t. There will still be outliers, there will still be people who have these problems and are not caught in the safety net. Some of the people that that question refers to were already in the safety net were already under the highest level of court commitment when they took the actions they took that brought attention to them. So those are real problems, making the service system better is one way to address that and make it more accessible making it more adequate In terms of recovery and the kind of services that people want to receive an seek out voluntarily are all components of answering that question but this bill doesn’t answer that question.

Outpatient Civil Commitment (SB 350)
Testimony of the Ohio Association of County Behavioral Health Authorities
Presented by Suzanne Dulaney, Esq. Associate CEO

On behalf of the Ohio Association of County Behavioral Health Authorities and the Alcohol, Drug Addiction and Mental Health Boards that we represent, thank you for the opportunity to express the concerns our members have raised about SB 350. While our Association has not yet taken a formal position on the bill, we have met on several occasions with NAMI Ohio on the topic and discussed some concerns that I will share with you today.

Ohio's Alcohol, Drug Addiction and Mental Health Boards are empowered by statute to plan, develop, fund, manage and evaluate community-based mental health and addiction treatment services. When it comes to involuntary commitment that currently exists for hospitalization when an individual is a danger to self or others, the role of the board is to assist the courts in determining whether someone should be subject to hospitalization and whether alternative services are available when someone is ready to transition out of the hospital level of care.

In addition to carrying out important governmental functions under the law, our Boards also feel quite strongly about being outspoken advocates for Ohioans with a mental illness or addictive disorder. Thus, any legislation that deals with the delicate balance between the individual rights and liberties of someone with a mental illness versus the interests of society – however well intentioned – will always be viewed with a critical lens.

Under current law, the word "hospitalization" is coupled with authority to involuntarily commit someone with a mental illness. We have historically agreed as a society that when someone clearly represents a substantial risk of physical harm to self or others, hospitalization coupled with due process rights is appropriate until competency can be restored.

Under an outpatient civil commitment model, the threshold for risk of harm to self or others is lowered and a court may order a person to comply with a specific treatment plan, usually requiring the person to take medication and sometimes directing other aspects of the individual's life.

A few Boards feel strongly that when safety is not an issue, treatment should be voluntary because they feel this approach holds the best promise for long-term treatment. For these communities, there is more of a philosophical difference of opinion on the matter of outpatient commitment and its utility.

Several Boards have indicated a willingness to rethink Ohio's approach and incorporate some model of outpatient civil commitment, but they have concerns about the specifics in SB 350 and resource concerns. Here are some of the concerns we have discussed:

- The list of items a judge can require as part of the "treatment plan" is overly broad. Financial services, addiction treatment, and "any other services" pose particular problems.
- There is a concern that prioritization of the Boards' extremely limited mental health treatment and support services funding would shift to those individuals whose family members are more sophisticated about accessing courts instead of based upon severity of illness.
- There is a concern about how courts across the state might use very different approaches to implement the law.

Suzanne Dulaney – Ohio Association of County Behavioral Health Authorities

Questions:

How would you resolve priority conflict if enacted?

In other words, we have slots for services that would be necessary to implement the treatment plan that that the Court would order. We have capacity issues there now so the tension would be these folks could jump in line even if there is someone more severely mentally ill already in the queue. How would that work at the community level. The only quick answer I can think of is sufficient capacity to address both people already waiting for those services and any of the new folks that would emerge in need of the treatment plan implementation. All the services that might come with that plan such that there doesn't become a conflict or such that you wouldn't have the local community being in the uncomfortable position. Saying I know you voluntarily want help but I am sorry the court has ordered help over here for this individual and I am sorry. The only thing I can think of is to address the capacity side of the equation.

How would you clarify the current law for all 88 counties?

One, I am a little nervous about trying to play Judge and handle the judicial branch about statutory interpretation. What I can tell you is that currently in the communities it is a wide and varied implementation of the law and it has varying interpretation. I would say the majority of interpretations because the word hospitalization is coupled with involuntary. I would say most of the courts that our boards work with seem to view the authority for outpatient in a limited manner. There are a few exceptions to that that I am aware of in some communities their working well with the behavioral health system and others not so much.

ASSISTED OUTPATIENT TREATMENT

"A STEP IN THE RIGHT DIRECTION"

Judge Randy T. Rogers
Jonathan Stanley, J.D.
May 12, 2004

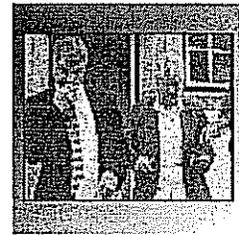
"But the voices... the voices told me to stab Mom in the heart," Jenny impassively recounted to the judge. Sitting in chairs positioned directly behind their daughter, her worried parents hoped the judge would understand that Jenny was not a bad person, but that she needed help they could not provide.

More than 10 years before, Jenny had been diagnosed with paranoid schizophrenia. Since then she had been taking medication prescribed by a psychiatrist and seeing a therapist on a fairly regular basis. But in the year before this civil commitment proceeding, Jenny took her medication sporadically and on 3 occasions was admitted to her local hospital's psychiatric ward. Each time she seemed to get better and was released after only a few days.

"I find that the respondent is a mentally ill person subject to hospitalization by court order," the judge delicately decreed, as Jenny's parents silently nodded their agreement. Jenny just stared straight ahead, lost in a world the others could not understand. "I further find that the least restrictive alternative available that is consistent with treatment goals is inpatient hospitalization at the state mental hospital," the judge continued, "and upon discharge from the state hospital, respondent shall be committed to the local mental health board to receive assisted outpatient treatment."



"...the voices told me to stab Mom in the heart."



"...her worried parents hoped the judge would understand..."

Assisted Outpatient Treatment (AOT) is a form of court mandated outpatient treatment that allows a mentally ill person to be treated in a much less restrictive environment than a state hospital while still allowing judicial monitoring of the administration of the person's treatment plan.

A generation ago, civil commitments to state mental hospitals were best measured in months or years. Assisted outpatient treatment has helped change that expectation. Assisted outpatient treatment (AOT) is a form of court-mandated outpatient treatment that permits a mentally ill person to be treated in a much less restrictive environment than a state hospital while still allowing judicial monitoring of the administration of the person's treatment plan. AOT is an effective alternative to the out-dated "throw away the key" custom of mental health treatment.

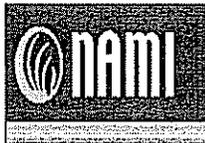


This progressive method of treatment mandates that those with a demonstrated inability to maintain psychiatric treatment in the community receive and participate in sustained and intensive treatment until once again able to manage their own treatment regimen. For someone incapable of making informed medical decisions, a typical 6-month authorized placement in an AOT program could mean a safety net of intensive and caring treatment rather than a spiral into psychosis and the intense restriction of an involuntary hospitalization. And, conversely, the intensive supervised treatment of AOT becomes a bar to re-hospitalization and a bridge to stability for many released from inpatient psychiatric facilities.



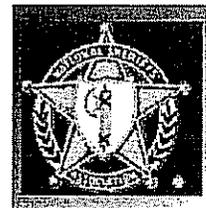
As stressed by an American Psychiatric Association Task Force on assisted outpatient treatment:

*Any humane and comprehensive quality mental health treatment system must make provision for both inpatient and outpatient involuntary treatment for those severely and/or persistently mentally ill who can benefit from such approaches.*ⁱ



National
Alliance
For Mentally
Ill

NAMI's *Policy On Involuntary Commitment* similarly holds that “Court-ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment.”ⁱⁱ Not surprisingly – since many tens of thousands of people with severe mental illness are jailed each year for lack of treatment – the use of AOT is promoted by correctional and law enforcement organizations like the **National Sheriffs’ Association**, which formally resolved to support “laws that allow a court to order treatment in the community for individuals who are in need of treatment but refuse it (also known as assisted outpatient treatment).”ⁱⁱⁱ



The effectiveness of court ordered outpatient treatment breeds such endorsements. A review of the available research literature on assisted outpatient treatment prompted the following conclusion in a resource document of the **American Psychiatric Association**:



...use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of re-hospitalization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness.^{iv}

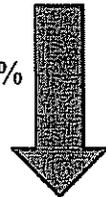
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Indeed, more than fifteen published studies have examined outpatient commitment for statistically significant value in facilitating and improving the care of those most affected by the symptoms of mental illness. All but two of those have determined it an effective treatment mechanism. In most cases, researchers have pronounced it a remarkable one.

A controlled and randomized study conducted out of Duke University is the largest and best examination of assisted outpatient treatment. The findings of this pre-eminent study include that AOT for 6 months or more combined with routine outpatient services (3 or more outpatient visits per month) **decreased hospital admissions by 57%** and the average length of hospital stays by 20 days; reduced the incidence of violence by half; and **decreased victimization of those under court orders by 43%.**^v Among those with a history of multiple hospitalizations as well as prior arrests and/or violent behavior, the re-arrest rate of those in under AOT was about one-quarter that of the control group (12% v. 47%).^{vi}



Decreased
Hospitalization – 57%
Decreased
Victimization - 43%



The results of one of the nation’s most used and perhaps best-known AOT programs, **Kendra’s Law** in New York, give real-world validation to the Duke findings. The **New York State Office of Mental Health** reports that of those placed under an initial Kendra’s Law order

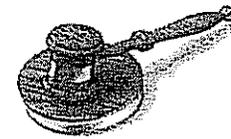
- **63% fewer experienced hospitalization**
- **55% less homelessness**
- **75% fewer arrest, and**
- **69% less incarcerations.**^{vii}

Additionally, 45% fewer harmed themselves and 44% fewer harmed others.^{viii}

The legal foundation on which the assisted outpatient treatment process has been built has been validated by a number of court decisions. As it has long been conclusively settled that courts can be empowered to commit individuals overcome by psychiatric disorders to the more restrictive setting of a hospital, judicial orders requiring compliance with treatment in an outpatient setting are clearly permissible. What legal challenges there have been have instead focused on the progressive eligibility standards incorporated in most of the more recent AOT laws.

The legal foundation on which the assisted outpatient treatment process has been built has been validated by a number of court decisions.

These criteria include considerations such as the need for treatment, the chances of deterioration absent it, the inability to function independently, and the capability of making informed medical decisions. Such standards have been upheld by the unanimous high courts of three states: Washington (1989), Wisconsin (2002) and New York (2004).^{ix} No significant challenge to an AOT law or its standard has succeeded despite the laws being in place in 41 states, in some of them for over two decades.



“Jenny is doing better now than she has in the last 12 years.”



Progress involves moving forward. Assisted Outpatient Treatment is a step in the right direction.

Assisted outpatient treatment can be very effective. Jenny's stay in the state mental hospital was only temporary. Within 90 days she returned home to her family. Although her court case remains open, her inpatient treatment has given way to outpatient visits to see her doctor and therapist. Each month she is invited to attend a status review hearing and speak with the judge. If all continues to go well, her case may soon be dismissed.

Jenny's case is not unique, but her treatment plan is not "the way it used to be done." Just as the discovery of new medications has made mental health treatment more effective, progressive changes in the way courts and treatment professionals handle civil commitment cases can also make mental health treatment more effective. In Jenny's case AOT has worked. At her last status review hearing, Jenny smiled broadly as her mother told the judge, "**Jenny is doing better now than she has in the last 12 years.**"

**Progress involves moving forward.
Assisted Outpatient Treatment is a step in
the right direction.**

End Notes

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- ⁱ APA Task Force, "A Vision for the Mental Health System" (April 2003)
- ⁱⁱ National Alliance for the Mentally Ill, Policy On Involuntary Commitment And Court Ordered Treatment (Approved by NAMI Board of Directors on October 7, 1995)
- ⁱⁱⁱ National Sheriffs' Association, Resolution 1999-69 (adopted by N S A. General Assembly on June 30, 1999).
- ^{iv} Subcomm. on Mandatory Outpatient Treatment, Am. Psychiatric Ass'n. *Mandatory Outpatient Treatment* 16 (1999).
- ^v Swartz, MS, Swanson, JW, Wagner, RH, et al: Can Involuntary Outpatient Commitment Reduce Hospital Recidivism? *American Journal of Psychiatry*, 156:1968-1975 (1999); Swanson, JW, Swartz, MS, Borum, R, et al: Involuntary Out-Patient Commitment and Reduction of Violent Behaviour In Persons With Severe Mental Illness *British Journal of Psychiatry*, 176: 224-231 (2000); Hiday, VA, Swartz, MS, Swanson, JW, et al: Impact of Outpatient Commitment on Victimization of People With Severe Mental Illness *American Journal of Psychiatry*, 159: 1403-1411 (2002)
- ^{vi} Swanson, JW, Borum, R, Swartz, MS, et al: Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness? *Criminal Justice and Behavior*, Vol. 28, No.2: 156-189 (2001)
- ^{vii} Memorandum from New York State Office of Mental Health to Jonathan Stanley, Treatment Advocacy Center (Nov. 4, 2003).
- ^{viii} New York State Office of Mental Health, *Kendra's Law An Interim Report on the Status of Assisted Outpatient Treatment* 12 (January 2003) (available at http://www.omh.state.ny.us/omhweb/Kendra_web/interimreport/).
- ^{ix} *In re Detention of LaBelle*, 728 P 2d 138 (Washington Supreme Court 1986); *State of Wisconsin v Dennis H*, 647 N.W 2d 851 (Wisconsin Supreme Court 2002); *In re K L.*, 806 N.E.2d 480 (New York Court of Appeals 2004).

Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

Testimony of Judge Randy T. Rogers from Butler County, Ohio

1. My name is Randy T. Rogers. I am the Probate Judge of Butler County, Ohio, and I have served in that position since February 1, 1995. Although I am an active member of the Ohio Association of Probate Judges, and I am a member of the Probate Law and Procedure Committee of the Ohio Judicial Conference, I am not here today as a representative of either of those entities. I am here only as an interested individual.
2. As probate judge in a Probate Court that has now has pending nearly 100 civil commitment cases, that were brought pursuant to the provisions of Chapter 5122 of the Revised Code, I consider myself a key stakeholder whenever Chapter 5122 is being discussed. SB 350 involves a clarification and possible expansion of the definition of the class of persons who may be named as a respondent in a Chapter 5122 civil commitment proceeding, and that makes me “interested.”
3. I have had an opportunity to read through the substance of SB 350 (Court-Ordered Outpatient Treatment) and I support the general concept of (1) clarifying the existing statutory process, and (2) updating the statutory definition of the term “mentally ill person subject to hospitalization by court order,” or as SB 350 proposes, the term “mentally ill person subject to court order.”

As a probate judge who regularly handles civil commitment cases, I am aware of the definition for the term “hospital” set forth in Paragraph (F) of section 5122.01 of the Revised Code, but I am also aware that once a probate court determines that a person meets the statutory definition of a “mentally ill person subject to hospitalization by court order,” that same court must then order placement taking into account the “least restrictive alternative available and consistent with treatment goals,” in accordance with the requirements of Paragraph (E) of section 5122.15 of the Revised Code.

Paragraph (C) of section 5122.15 specifically contemplates orders of commitment to “a board of alcohol, drug addiction, and mental health services, or agency the board designates,” [Subparagraph (C) (4)] “receive private psychiatric or psychological care and treatment,” [Subparagraph (C) (5)] and “any other suitable facility or person consistent with the diagnosis, prognosis, and treatment needs of the respondent.” [Subparagraph (C) (6)].

In my previous rulings I have always been of the opinion that the existing statutory language contemplates civil commitment orders that involve persons who may not be residing inside a hospital. The interpretation of the term "hospitalization by court order," in my view, should be made *in pari materia*, taking into account the language of all statutes on the same subject or relating to the same matter.

To the extent that there exists any confusion in the application of current law, as to whether or not civil commitment orders may involve persons who are either not being treated in a hospital or who will not be treated in a hospital, then I am in support of amending the statutes to make it more clear that mentally ill persons, who otherwise meet the required statutory criteria, but who are not being treated in a hospital or who will not be treated in a hospital, may be the subject of a civil commitment order.

Proposal to delete the words "hospitalization by" from the definitional language now found in Paragraph (B) of 5122.01.

One of the significant changes suggested in SB 350 deletes two words, "hospitalization by," from the current definition found in the first portion of Paragraph (B) of section 5122.01, changing the phrase "a mentally ill person subject to hospitalization by court order," to "a mentally ill person subject to court order." I would support that change. I also agree with many of my fellow probate judges that this particular issue might also be the subject of more comprehensive educational programs on the existing civil commitment process in Ohio. I am aware that one such educational program is being planned for March, 2013.

Proposal to restate Paragraph (B) (4) of section 5122.01 of the Revised Code.

A major change suggested by SB 350 is to amend and restate Paragraph (B) (4) of section 5122.01 of the Revised Code as follows:

- ~~(4) Would benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person due to all of the following:~~
- (a) The person is unlikely to voluntarily participate in treatment.
 - (b) The person has demonstrated difficulty in adhering to prescribed treatment.
 - (c) The likelihood that, if the person is not treated, the person's current condition will deteriorate to the point that the person will meet the criterion in division (B)(1), (2), or (3) of this section.

It is beyond the scope of my testimony today to express any opinion about the constitutionality of this language. I have previously provided to your Committee a copy of a law journal article dealing with the constitutionality of similar provisions. I am also aware of the successful passage of "outpatient commitment" language included in recent enactments made by other states. On this topic, I refer the members this Sub-Committee to summaries that have been prepared by an

organization known as Treatment Advocacy Center, based in Arlington, Virginia.
See: <http://www.treatmentadvocacycenter.org/legal-resources/state-standards>

4. In my view, existing Ohio law already allows for various forms of court ordered outpatient commitment. Commitment orders using Paragraph (C), (D), or (E) of section 5122.15 are all forms of court ordered outpatient treatment. In Butler County, we regularly make the commitment using Paragraph (D) of section 5122.15. Although the current law is adequate, in my view, Ohio citizens would benefit if the law in this area were modernized and expanded to reflect 21st Century treatment realities.

SB 350, or some form of a SB 350, is needed to begin the process of reviewing Chapter 5122 in light of the currently predominant practices in mental health treatment. Since the definitions found in section 5122.01 of the Revised Code first went into effect, state hospitals have been closed and hundreds of hospital beds that were once used for the treatment of persons with severe mental illnesses no longer exist. As poor substitutions for adequate treatment facilities, county jails and state prisons have unwillingly become the new mental health “asylums” in Ohio.

I have presided over civil commitment cases of approximately 1000 different people during my tenure as a probate judge. During this period of time I would estimate that, on average, at least 80% of those under commitment by an Order from our Court were not being treated in a hospital as such. I have been a proponent of outpatient commitment for many years and articles that I have written on this topic have been posted on the website that is now associated with this Sub-Committee.

In my view, as far as outpatient commitments are concerned, the current law is not being used optimally in Ohio, for a variety of reasons. Those reasons include:

(1) grossly inadequate funding of the cost of the court proceedings. (Since 2005, when the amount of funds ODMH made available for the reimbursement of the costs of court hearings held under Chapter 5122 was \$989,364.00, the amount has decreased by 2012 to only \$584,210.00, a decrease of more than 40%. This “push-back tax” has significantly undermined existing outpatient commitment processes and has effectively blocked the enhancement of those processes.)

(2) the differing interpretations of existing statutory language and the differing application of various court rulings by members of both the legal and mental health treatment community;

(3) lack of the relative priority given by the ODMH over the last several years to the continuing development of the civil commitment process in Ohio;

(4) the long-standing practice of transferring civil commitment cases from the counties where patients reside to counties in which a state hospital is located.

5. I personally do not oppose SB 350, although I recognize that it is an expansion of existing law and will likely increase the number of 5122 commitment cases filed in Ohio courts.
6. As an individual, I do support passage of some form of SB 350, but strongly suggest that any changes that expand the criteria under section 5122.01 of the Revised Code be accompanied by a firm commitment from those who control the state budgets to fund the changes. To make any changes at this time, other than to clarify what is already there, after the funding of the commitment process has so recently been cut by more than 40%, but to not fund the expansion of the criteria, would give false hope to the families of persons who have severe mental illnesses.
7. Other than the financial concerns for the court system, which I have already expressed, I see only positive ramifications when some form of SB 350 is passed.

At a personal level, my views have not changed since I first began, more than twelve years ago, to look into the area of the outpatient commitment process. I offer as a summary of my personal views, a copy of an article I co-authored several years ago, an article which was written to be distributed as a handout at the annual convention of a state mental health organization. The article is dated, but then so am I. The statements made in the article, however, are as true today as they were when they were originally written.

In summary, court ordered outpatient commitment works. It is, and always will be, at least in my view, a benefit to (a) people with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community; (b) family members of people with SPMI; (c) providers of services and supports for people with SPMI; (d) probate judges and courts; (e) law enforcement officers; and (f) society in general. For years, I have watched it work.

Thank you for allowing me to share my observations and views today.

Judge Randy Rogers – Probate Judge

Are you aware of the letter to Ohio Judicial Conference provided to Senator Burke (the sponsor) expressing concerns with SB 350? Can you explain the differences between your position and OJC's Position?

I am aware of the letter and I think how I put this, the letter was written by an attorney and we attorneys think differently and I don't think that the gist of the letter was as it was interpreted. There are always issues having to do with constitutionality, there is always issue about that. When the bill was reintroduced I would suggest that perhaps there might be a new letter and I will just leave it at that. I hope that answers the question. I am here speaking in part on behalf of the Probate Law Procedure Committee of the Ohio Judicial Conference so it's very possible that there are some meetings that I missed or that I didn't pay attention to all of.

Why do believe there is such a difference across Ohio's 88 counties with regard to application of the current outpatient commitment law? (This difference existed prior to the reduction of dollars available?)

I would indicate to you that the introduction of this bill has created the dialogue that did not exist before. There is already educational program one of which I believe is being planned for March of 2013 for Probate Judges throughout the state and that is the deal with some of the variance of terms of interpretations at the same time. That's where clarification would be helpful, I agree with other the Judges support the gist of 350 in terms of clarifying the same because there seems to be some confusion about it. I also agree with other Judges it also could addressed to some educational programming some of which is already planned. In terms of why is there such a variance, I would indicate to you my own personal opinion that one of the reasons has to do with the practice developed many many years ago transferring all or most of the cases handle in Ohio are done by just a handful of Courts and I think one Court takes up 22 counties and those counties simply transfer their cases where there is a State Hospital. Another county takes like 14, I don't know how many counties Franklin County takes I know that as I understand they run in the whole about \$300,000.00 a year in terms of processing those cases because the cases come but the money doesn't and it has created great fiscal problems. That fact is one of the reasons that there is a variance in terms of the application. If you send all your cases to another county then you are not going to have an outpatient commitment program in your local county because those cases don't go back. There are some judges that are trying to address that now but the reality is if you're going to have outpatient commitment in my view it's got to be local and it's got to be done by the local boys. When everybody takes their case ships them off to another county because they have to have a state hospital there it will be much more difficult to have an effective outpatient commitment program. Another reason for the variance in my opinion is the lack of relative priority and I am not criticizing ODMH but I would indicate to you I have been in this business for a long and I have never thought of the ODMH as being one of the leading voices on civil commitments, as a of matter fact the only time I have ever heard from ODMH on civil commitments it had to do with why we can give you

more money and why we can't change the way the allocations are done, The last thing I heard from ODMH on the topic was that we are sorry that the legislature cut the money please contact your legislators. Sorry that legislature cut the line item on the other hand ODMH has a whole lot more money and I would have that money come from some other sources. I never looked at ODMH as one of the leaders in the cause of civil commitment process in Ohio, that's a personal view and it's not meant to be a criticism. They have a lot of other things to do and they have their own priorities that they set and civil commitments has never been a priority of the Ohio Department of Mental Health at least during my tenure and again I do not state that as a criticism. They have their right to set their priorities and they have a lot to do and I believe that their priorities is outpatient treatment and not outpatient commitment but within outpatient treatment, my view is that you have to allocate some resources to outpatient commitment. If your serious about outpatient treatment, that's my view. The other reason for the different variance is that you have some appellate court decisions that are at odds and an example would be the use of treating physicians which is a widespread practice throughout the state yet there are a couple districts you cannot do that. There are other case law issues that have to do with the interpretation of that case law.

Is the current statute in your opinion underutilized and if so Why?

If the question relates to outpatient commitment it is not being used optimally for the reasons I just gave. The ones who works in this area have to look at the big picture yet the local boards and the state do not have the funds to have the allocate, then they are going to choose what they believe to be most important to allocate those funds. What I'm here for is to raise awareness from the point of view from a Probate Judge that's handled more than 1000 different cases different people that in my view the attention to the outpatient commitment portion to outpatient treatment could stand to have a little attention. It's worked well in other states and I believe it would work well in Ohio. We are not using what we have but it's probably more financial than it is anything else, there are many Judges that are trying to innovate. I spent an hour on the phone Monday with a Judge that's trying innovate and the struggle has to do with not being able to pay for profit, not having the willingness to try to do a better job. I have tried to communicate that these are not just cases to us these cases represent people and they are very personal and you cannot handle these cases without them have some impact upon you.

Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

**Testimony by Jack Cameron, MPA
Executive Director, Ohio Empowerment Coalition
November 7, 2012**

Questions for Key Stakeholders

- 1. What is your Name?** Jack Cameron.
Do you represent an organization (association)? Organization.
If organization, state the name of your organization and your position with this organization. Ohio Empowerment Coalition, Executive Director
(Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)
- 2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.**
As a statewide advocacy organization for persons with severe mental illness, the Ohio Empowerment Coalition is committed to protecting the civil rights of its 1,000 estimated members and countless other consumers who are not officially OEC members.
- 3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.**
The OEC position is summarized on our website and copies of our SB-350 Position Statement are available here with today's handouts. Our concerns regarding SB-350 are that it is the wrong set of solutions to the problem that NAMI is trying to address.

We agree with NAMI that we need a better plan to find support for persons who have a mental illness and could be potentially dangerous. The events in Arizona, Aurora, Colorado and Pittsburgh have demonstrated that we have a very serious problem. In each of these cases, a person of high intelligence and great potential, behaved violently and lives were tragically lost. The general public believes that the public mental health system has an obligation to treat those most at-risk of being a danger to themselves and to the rest of society. Unfortunately, all too often, we fail to provide the treatment interventions necessary to protect the mentally ill person and those around he or she.

Having worked at a Community Mental Health Center in Canton for 7 years, I witnessed the cases of difficult to engage clients being closed all too often.

Labeled “non-compliant” or “uncooperative”, these individuals were excluded from the case rosters of these mental health centers and left to flounder. Many have ended up in the prison system, which is even less-equipped to provide care for their unique treatment needs.

This issue of access to appropriate treatment has become a greater problem since 2008, when the State budget crisis led to deep cuts in mental health funding at both the state and local level. Cash-strapped mental health treatment organizations are increasingly dependent on Medicaid dollars to run their programs. Unfortunately, Medicaid billable services fall well-short of the services needed to reach difficult to engage persons. But the Medicaid dependency dictates that agencies are limited in the options that they can offer clients.

For the past 15 years or so, Ohio and the rest of the United States have discovered that mental health recovery is not only possible for most persons with a mental illness, but expected when recovery supports are provided. Supportive Housing, Peer Support, Supported Employment, ACT Teams, homeless outreach programs and a host of recovery tools have transformed mental health treatment. We know that these programs work and they are generally less expensive than the typical Medicaid billable services. A key ingredient is that the person who has the mental illness has control of the direction of his or her treatment. When the client is actively involved in all phases of treatment planning, there is a commitment to work the plan with the help of these traditional services, along with recovery supports.

We point this out in order to illustrate that SB-350 is a very “anti-recovery” law in the way that it is designed. The law assumes that parents, friends, neighbors and judges know more about what is best for the person than the individual himself. When people are forced to do something against their will, they are not truly committed to a solution. They may comply for the duration of the state’s control of their behavior, but results will be fleeting and this could engender in that person, resentment of the provider organization, the family and the court. Resentment, coupled with all of the chaos of a psychotic episode, could actually increase the potential for violent behavior, rather than the desired outcome of reducing violence.

Our other chief concerns are listed below:

- No effort to use WRAP (Wellness Recovery Action Plan) or Psychiatric Advanced Directives as crisis management tools, rather than rely on coercion.
- Lack of oversight. The absence of checks and balances is troubling to mental health consumers.
- Implementation plan is absent. The provider community is still adjusting to four years of budget cuts. Access to services is already an issue, without the new burden of pushing some people to the front of the line at

the expense of others. We expect to see SB-350 used to manipulate access to services by overstating the level of dangerousness in order to become “preferred customers” in the queue.

- Education and outreach. In order to have the desired effect that NAMI is striving for, massive education and outreach will be required. The OEC would commit resources to this effort if we had a bill that respected the civil rights of consumers.

SB-350 is a huge over-reach in the scope and severity of its effect of the civil rights of consumers. It is far more intrusive than New York’s Kendra’s Law. In NAMI’s list of proposed outpatient treatment orders, the most troubling in Number #9:

“9. Any other services prescribed to treat the person’s mental illness and to either assist the person in living and functioning in the community or to help prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.”

Any other services could be Christian Counseling every Tuesday. The law also is expansive in the duration of the mandated treatment. In what other health care realm would we prescribe something indefinitely.

4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed?

We believe that judges already have the tools intervene. If there is confusion, we could spend energy on educating decision makers.

Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio?

If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.

We have some experience in court ordered outpatient treatment. We acknowledge that these measures are sometimes necessary when the person’s judgment is significantly impaired. When administered correctly, this treatment can be reduced or changed over time as improvement in mental status dictates.

5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.

If the law were more “recovery-oriented” and geared toward a treatment partnership that utilize Certified Peer Specialists, we could support it. We would

like an Ombudsman component as a check and balance so that treatment is not arbitrary or coercive.

6. **If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.**

N/A

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

7. **Please discuss any positive or negative ramifications you think SB 350 will have for the following:**

- a. **People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;**

We believe that it is important to connect with these individuals so that they participate in their treatment for the long run. The connection is more important than the mandated treatment options.

- b. **Family members of people with SPMI;**

There is the potential for families to exploit this law in order to coerce or control their adult child.

- c. **Providers of services and supports for people with SPMI;**

Providers are already overburdened by documentation obligations, regulation, red tape. SB-350 can only make this worse as the provider struggles to obey a court order.

- d. **Probate Judges and Courts;**

Judges are already over-burdened with large case loads. They may feel a pressure to use this new law to excess, in order to demonstrate diligence. This could lead to over-use of treatment options that do not appeal to consumers.

- e. **Law Enforcement Officers;**

The law enforcement officers that I have spoken to say that they do not have time to hunt down clients and drag them to provider organizations. They view the law as potentially burdensome to their daily responsibilities.

- f. **Other**

8. **Is there any additional information that you would like to share with us regarding your position on SB 350?**

In closing, we would ask that all of the stakeholders in the SB-350 arena try to imagine what it is like to be a person that must deal with a severe and persistent mental illness. Besides the symptoms, much of the anguish of living as a mental health consumer is their own perceived lack of control. Lack of control of their

thoughts and feeling during times of crisis. Lack of control of their environment, opportunity to work and participate fully in their community, lack of choice about where they will live, what their goals for the future will be.

For recovery to take place, we need to have choice. When we have options, we feel more empowered. Even the person who is experiencing psychosis, they fear this increased lack of control. To have your rights suspended or taken away is a de-humanizing experience. It makes us feel less than whole person. SB-350 has the potential to do a great deal of damage to the self-esteem of persons in recovery. The United States culture values freedom and personal choice. We urge stakeholders to consider the impact of the way SB-350 works. There are two reasons why we incarcerate people in the United States. The first is for those who break the law, criminals. The second reason is to protect people who are not mentally competent. In both cases, this loss of freedom and choice is an overwhelming event. People in recovery deserve to have as much choice as possible. The outcomes that we all desire are far more likely when freedom and choice are preserved. While well-intended, court orders fall way short of fixing this complex problem.

Jack Cameron – Ohio Empowerment Coalition

From the story you told about the young man that was stalking your daughter, how would you get the proper services to that person if he did not recognize his illness?

Actually, that was the case in this particular case, the young lady that he was stalking really did try to tell him hey you know have you considered going in and getting some help and he of course did not think he needed to do that. So I think there does have to be a mechanism to address that and for me it's that I think that we need to have, we have act teams that are for people who are actively enrolled and are willingly enrolled in treatment. I think we need the same concept for people who are not enrolled and who may resist treatment but there are ways to engage people like John Shick. I have discovered that from working at the Gathering Hope House, I worked at recovery center in Elaine where we had to find mentally ill homeless people. Many of them are very paranoid, they thought we were the Government. They were very suspicious of us but by using donuts we got from the donut shops that were a day old and coffee, we went out the camps where these homeless people work and engage them very gradually by providing food and comfort. I think with this person here and with the other people we have talked about who ended up killing people, what was missing was nobody stepped up to try to make that engagement in a way that would of worked. So my strategy would be lets set aside some dollars even though the system is broke. I understand that, but let's set aside some dollars to reward organizations to take that extra step because right now it's too easy to walk away.

Would you change your opinion if the individual develops the treatment plan with the team and if WRAP, Peer support were also included?

Yes, we all agree the person needs treatment but when you have WRAP plan then you have a system where the person is involved in that treatment and are participating in and they believe in it and they sign off on it. Absolutely, we would do that and I think that is really what our biggest trouble with it has been that it's all this level up here of coercion. I know that a person in that state is a mess a lot of times and their life's in chaos but even in that psychotic state there's an awareness that their being controlled. There is a resentment to that control there really is and in the case of John Shick he was one pissed off guy after he got kicked out of Grad School. His dreams were gone and so you had a very agitated person then with few options. The University could have had a behavior management plan that said if you go in and get treatment and show progress we will readmit you next semester that could have been all the difference in the world for John Shick.

**Attorney General's Task Force on Mental Illness and Criminal
Psychiatry and Treatment Sub-Committee**

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony
Tuesday, November 13, 2012

Questions for Key Stakeholders

1. What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)

My name is Michael Ranney and I am Executive Director of the Ohio Psychological Association. The Ohio Psychological Association is the professional association for psychologists in Ohio. We have over 2,000 members around the state, including licensed psychologists who work in a variety of settings, psychologists doing research in academic institutions, graduate students and retired psychologists. Our Association supports passage of SB350.

2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.

This issue was brought to our attention by members of our Public Sector Issues (PSI) Committee. In our organization structure, the PSI Committee is one of our 10 standing committees. It includes psychologists who work in or consult with community mental health programs, psychologists who work for the Department of Mental Health, Department of Rehabilitation and Corrections, VA

psychologists and psychologists who work with the Ohio National Guard. Dr. Fred Frese, who is an active member of this committee, provided the primary leadership to bring this issue to our attention and inform us of the legislative changes that would resolve the confusion around current law.

3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.

Our Advocacy Committee reviewed this issue and came to the conclusion that this legislation was needed and that OPA should support it. OPA does much of its advocacy work in collaboration with other organizations and SB350 is no exception. We consulted with the National Alliance on Mental Illness in Ohio (NAMI-Ohio), which ultimately developed a coalition to focus on the details of what legislation should include. We have partnered with NAMI on other issues and respect their understanding of the personal and societal impact of untreated mental illness.

When we contacted NAMI they were already aware of the issue, having been contacted by NAMI Franklin County and some of its members about problems families were having getting children and young adults into treatment. Treatment was not

available unless there was an immediate threat of suicide or violence. NAMI reached out to the Ohio Psychiatric Physicians Association to create a coalition of work on legislation. We looked at the outpatient treatment processes used by different counties. The inconsistency underscored the confusion under the current law and provides the rationale for our support of SB350. Four specific areas of concern that needed attention were identified.

4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.

The current law was a step in the right direction and we strongly endorse the emphasis that Ohio's laws place on using the least restrictive alternative available. Here is the problem with the current law: ORC Section 5122.15(C)) says: "If, upon completion of the hearing the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to hospitalization by court order, the court shall order the respondent for a period not to exceed ninety days to any of the following...." A list of options follows. In (E) the law goes on to say "in determining the place to which, or the person with whom, the respondent is

to be committed, the court shall consider the diagnosis, prognosis, preferences of the respondent and the projected treatment plan and shall order the implementation of the least restrictive alternative available and consistent with treatment goals.” Data collected by NAMI indicates that only a few probate court judges in Ohio realize that court ordered outpatient treatment is an option. Most courts are reading the law as reading that hospitalization is the preferred and, perhaps only, option.

The coalition determined that the fix to this was to change the law so that instead of saying “mentally ill person subject to hospitalization by court order” it would read “mentally ill person subject to court order”. This removes the emphasis on hospitalization.

The second problem area was with regard to the definition of “mentally ill person subject to court order”. The fourth criteria listed in Section 5122.01 says they “would benefit from treatment in a hospital for the person’s mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk of substantial rights of others or the person.” This doesn’t fit very well with the other criteria, which

focus on risk of harm to self and others. The Coalition came up with the proposal that ‘the person would benefit from treatment due to all of the following:

- *The person is unlikely to voluntarily participate in treatment*
- *The person has demonstrated difficulty in adhering to treatment*
- *The likelihood that, if the person is not treated, the person’s current conditions will deteriorate to the point that the person will meet the criterion in above*

Third, since the Ohio Revised Code does not define what is included in a treatment plan in an outpatient setting, our proposal includes a definition in Section 5122.01 (V)

NAMI suggested, and we agreed, that as a fourth change to the law should include putting the Affidavit of Mental Illness form in Section 5122.13 and clarifying that the form should be filed with the Common Pleas Court. This recommendation is intended to make it easier for family members to find the form and understand where they should file it.

5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.

NA

6. If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

NAMI and our coalition partners invested a significant amount of time looking at the current law and investigating how it is being implemented. I think the recommendations that were developed address the issues that were identified.

7. Please discuss any positive or negative ramifications you think SB 350 will have for the following:
- a. People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;
 - b. Family members of people with SPMI;
 - c. Providers of services and supports for people with SPMI;
 - d. Probate Judges and Courts;
 - e. Law Enforcement Officers;
 - f. Other

We believe that these changes are sound public policy to help judges work with families who have a relative with untreated mental illness to find appropriate treatment before their illness progresses to a point that they must be hospitalized or incarcerated. We believe that SB350 makes it clear that outpatient commitment is an option for courts to use in appropriate situations. Use of this option can be more efficient, provide better care and be more cost-effective than hospitalization or incarceration, than allowing people to go untreated

until their illness becomes more severe, or than having them go to emergency rooms for care. We believe this will be beneficial to family members who have been completely at a loss for ways to deal with a relative with untreated mental illness. We've tried to be cognizant of the rights of the individual in crafting these changes, including due process, the right to legal counsel and the right to independent assessment.

8. Is there any additional information that you would like to share with us regarding your position on SB 350?

I want to thank you for the opportunity to discuss our interest in and position on this legislation. A number of our members have been involved in the work of the Attorney General's Task Force on Mental Illness and Criminal Justice. We appreciate the time and effort that is going into making a positive impact in an important area. We believe it is important to get input from all stakeholders on issues like this in order to make better public policy.

We had the Attorney General speak at our recent Annual Convention about the work of the Task Force. Justice Evelyn Stratton also presented and we were pleased to give her our Award of Excellence for her long-standing interest in this area of mental illness and criminal justice.

We thank Senator Dave Burke for taking the lead on this bill and thank Senator Seitz and Senator Jones for signing on as co-sponsors.

I also want to acknowledge NAMI-Franklin County, NAMI-Ohio and the Ohio Psychiatric Physicians Association, our coalition partners, who have devoted countless hours, energy and thought to the work leading up to SB350.

Michael Ranney –Ohio Psychological Association

Could you explain any negative issues that you see with this bill?

I have heard of some of the issues that some of the other stakeholders has raised I'm not sure that I share the actual opinion that they are actual negative issues but certainly things that we consider as we move forward realizing that this bill is not going to pass this session and there is still time to be looking at this very carefully considering the perspective of all stake holders. I know there some legal issues that have been raised about possibly forcing medication on people which is certainly not the intent of the law and if there is anything in the changes in the law that have been suggested that would support that we would certainly want to see that changed. We have also heard that some of the Judges realized that this was an option and that they don't think they need this law. I'm not sure that I agree with that perspective with the evidence that NAMI particularly gathered from Courts around the state suggest that many Judges just weren't aware this was an option so I do think that the law is needed.



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ATTORNEY GENERAL'S CRIMINAL JUSTICE – MENTAL HEALTH TASK FORCE

S.B. 350 Court Ordered Outpatient Treatment – Stakeholder Comments

Teresa Lampl, LISW-S, Associate Director
November 13, 2012

Thank-you for the opportunity to share feedback on S.B. 350, which proposes to make changes to Ohio law related to court ordered outpatient behavioral health treatments. My name is Teresa Lampl and I am Associate Director with the Ohio Council of Behavioral Health & Family Services Providers, a statewide trade and advocacy organization that represents 150 non-profit community mental health, addiction treatment, and family services providers that employ over 18,000 professionals and serve over 600,000 Ohioans annually.

Today, the Ohio Council would like to offer comments as an interested party to S.B. 350. Ohio law currently allows for assisted outpatient treatment or court ordered outpatient commitment and there are individuals that truly benefit from this level of intervention due to the severe impairments created by their mental illness or substance abuse. The goals of S.B. 350 are well intended and are offered as an approach to save lives, save money, and help families care for their loved ones. However, we are concerned that the changes proposed in S.B. 350 do not simply clarify existing statute, but rather substantially change the legal landscape and have many unintended consequences.

We are aware that some probate courts have been successfully using court ordered outpatient treatment under existing state law. Our principle recommendation is that Ohio should look to those courts to understand how assisted outpatient treatment can be used and develop a judicial training and education model to promote the full use of existing statutory provisions across all 88 counties. As such, S.B. 350 would not be necessary.

As currently drafted, we have a number of concerns with S.B. 350 and how it proposes to change Ohio's court ordered treatment statute. We will briefly summarize our questions and concerns below:

1. As proposed, S.B. 350 disrupts the balance of an individual's autonomy and personal right to choose with that of their family members when a person is a "mentally ill person" as defined in statute. While intended to help families trying to help a seriously mentally ill loved one obtain needed treatment when the illness itself impairs decision making, it also throws open the door for court action in situations where exploitation, intimidation, and other malicious motives drive case filing. It further perpetuates the stigma of mental illness by setting a different standard for health care decision making when a person has a mental illness. It is very rare in health care that courts are asked to intervene and order treatment(s) an individual does not choose for all other health conditions, including other diseases that alter cognitive functioning. If behavioral health care is health care, how do we safeguard

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the individual's right to self-determination and autonomy while recognizing the impact of the illness on decision making in a manner that is consistent across health care.

2. There is no reference to or acknowledgement of psychiatric advance directives, which may also inform treatment professionals and or/the court of an individual's preferences for health care treatment during a recurrence of the mental illness that may impair the individual's decision making.
3. The bill does not provide clear accountability, oversight, or procedures to assure the person subject to court ordered treatment is able to assume responsibility and control of their treatment decision making as soon as possible or establish clear criteria for when a person may resume control of their health care decision making.
4. The re-defined criteria in ORC 5122.01 (B)(4) defining a mentally ill person subject to court order indicates that a person must meet all three elements – will not voluntarily participate in treatment, has difficulty adhering to treatment, and is likely to become a danger to self or others. To meet the third element of this section implies there is an assessment of dangerousness. The science of predicting dangerousness is still evolving and while there are many tools to assess "dangerousness", research has largely focused on evaluation of criminogenic factors rather than interpersonal factors. Will the courts rely on family member's assessment of dangerousness within a signed affidavit? Who will the courts rely on to assess and predict dangerousness?
5. ORC 5122.11 and 5122.111 indicates a "person or persons" shall file an affidavit with the probate court to initiate court ordered treatment. It implies that any person can file the affidavit and that professionals, family members, or other concerned parties will use the same format that is now codified in the administrative code. We would like to understand how the the probate court will obtain information from licensed treatment professionals when a person is not currently in treatment or has not been seen by a treatment professional prior to filing the affidavit? In these circumstances, will the court order a person to be picked up by law enforcement to be evaluated?
6. S.B. 350 gives the probate court discretion to commit a person to the Ohio Department of Mental Health, an ADAMH Board, or a treatment provider and permits placing a person in a hospital or "other place for designated treatment" and the person can be observed and treated pending a hearing. It is not clear whether a person is required to be hospitalized when subject to court ordered treatment via affidavit. Is a person required to be hospitalized if an affidavit is filed seeking court ordered treatment and the person is not willing to comply with a prescribed treatment plan while the court determines whether a person is a mentally ill person subject to court ordered treatment? What may be considered as "other place for designated treatment"? What is the role of ODMH, ADAMH Board, or treatment provider while a person is awaiting a hearing on an affidavit but not hospitalized?
7. While some individuals with a mental illness will respond to court ordered treatment, accept the recommended course of care, and comply with treatment, others will not. When the "black robe" effect does not result in treatment compliance, it is unclear what happens next. Is the court expected to order involuntary hospitalization? Is the individual incarcerated? What is the next step or alternative? What safeguards exist to assure this section of the code does not result in the criminalization of mental illness?

8. Changing the language from “mentally ill person subject to hospitalization by court order” to “mentally ill person subject to court order” may create barriers in actually accessing hospital levels of care when appropriate. By simply removing “hospitalization” is there an unintended outcome that makes it difficult for physicians, psychologists and designated health officers to involuntarily admit a patient for inpatient hospitalization when they are a danger to themselves or others because the court must now consider outpatient commitment?
9. Treatment planning and place of service is determined by the court. The bill does not indicate how the treatment team is involved in developing a treatment plan or how a treatment team is established if an individual does not have an existing treatment team. Furthermore, the services listed under the definition of treatment plan in ORC 5122.01(V) do not represent a comprehensive continuum of care, some services may not exist in every community, and are likely to be interpreted as the services that should be considered by the courts. What safeguards are in place to assure that clinical care and the treatment plan is recommended by licensed treatment professionals and considers the full continuum of care as well as treatment availability in the local community? Furthermore, several of the services listed under (V), such as housing or supervised living services, are not reimbursable by insurers (public or private). If ordered by the court, will the court assume responsibility for payment for these services, and if not, who is expected to pay for the cost of care?
10. The legislation implies treatment and support service capacity is available. Given the state budget cuts for behavioral health services in the recent past, shortage of psychiatrists and child psychiatrists, and fragmented continuum of care across Ohio, we are concerned this legislation assumes resources and appropriate or needed treatment and support services are already available and accessible in the community. Additionally, we are concerned court ordered treatment may be viewed as a mechanism to jump to the front of the line when there are waiting lists or other local mechanisms for determining priority of services.
11. This legislation creates demands on the probate court system and places probate judges in the role of gatekeepers to the behavioral health system. We are concerned individuals and families will use the probate courts as a means to access behavioral health care because they cannot currently access treatment because of lack of insurance, lack of service capacity, or lack of availability of needed services or professionals. Probate judges are likely to need additional education and training to understand serious mental health conditions, the interaction of co-occurring mental illness and substance use disorders, medication use and best clinical practices, and best practices for treatment serious and persistent mental illness.

Thank-you for the opportunity to share these comments, questions, and concerns. The Ohio Council understands court ordered outpatient treatment may be necessary to assure personal and community safety so that individuals that are unable to care for themselves can receive care they need to preserve life when all other reasonable options have be exhausted. We hope the comments provided today are helpful and we strongly encourage advocates, legislators, and state leaders to learn from those probate courts that are already using assisted outpatient treatment to develop training and tools to assist probate judges and courts on how to use court ordered treatment under existing Ohio law across the state.

Teresa Lampl – The Ohio Council of Behavioral Health & Family Service Providers

Are you aware of how many suicides and accidental deaths are recorded in Franklin County Coroner's Office? How would you prepare legislation to get access to mental health care on a moment's notice?

To answer the first part of the question about suicides. I am aware of the prevalence of suicide and we need to do a much better job in preventing suicide in this State and this Country. Suicide is a product of this illness and can be readily prevented. I don't think there is any question that we need to do a much better job and provide resources for doing a much better job in intervening when someone is suicidal. To answer the second part of the questions which was related to legislation. I think this is the challenge that we face not just in mental healthcare but in healthcare in general how do we create access and capacity. We live in a state where we have seen dramatic budget cuts for behavioral health care services and so as dollars have been cut we lose resources and we don't have the work force. I'm fully aware that we have looming work force shortages in health care in general but specifically in behavioral health care, we have a shortage of psychiatrist. We have to start as a long term strategy how do we build the infrastructure that we need that will provide the type of immediate access to services that we need. Now that's a long term situation and doesn't address the immediate situation. I think immediately its some of the things we have recommended how do we work with hospitals, how do we look at some of the health care reforms that are going on particularly around health homes for persons with serious and persistent mental illness. How do we get people engaged in care and much sooner and keep them engaged in a long term process where we are working and focusing on their total health. Not just focusing on their mental health issues because a lot of times it's the interactions of those two things that drive the continued downward spiral cycle that leads to the poor outcomes that we are talking about that lead to suicide that lead to tragedy. So we need to do a better job in the short run and it's not going to be a silver bullet. There is no one immediate thing that we can do that will create immediate access anytime a person needs it. But I think we can do a better job and I think there's a lot of things we are trying to do working with our hospital systems working with the capacity that we have to get people in to care and to start doing a better job of managing the population and doing population based care as well as working with individuals that are in a crisis.

Can you agree that the actual treatment plan developed based on this legislation could address and clarify many of your concerns?

No I could not agree with that statement because it's not clear in the legislation who is responsible for developing a treatment plan and how the clinical care is determined and how payment will be arranged for those services. So in putting the treatment plan responsibility at the Court level there is not consistence or clarity that you will have professionals driving the treatment and working with the individual and the family and understanding their individual needs holistically to get them the types of services that they need to achieve the type of recovery that we want for the folks we are talking about.

Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

Questions for Key Stakeholders

1. What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)

Kristina Ragosta, Esq., Senior Legislative & Policy Counsel representing the Treatment Advocacy Center.

2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.

The Treatment Advocacy Center (www.treatmentadvocacycenter.org) is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness. We are nationally recognized for our expertise in mental health treatment laws. We routinely provide research and consultation to state legislatures. We frequently hear from Ohio families who have struggled to get help for a loved one overcome by severe mental illness.

3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.

The Treatment Advocacy Center supports SB 350. The current law that permits court ordered outpatient treatment is confusingly titled "mentally ill person subject to hospitalization by court order."ⁱ As a result, many do not think it authorizes court-ordered outpatient treatment. In addition, changes to the fourth commitment criteria are necessary to ensure clarity.ⁱⁱ

Involuntary mental health treatment laws and constitutionality

Every state has some form of involuntary mental health treatment. Forty-four states permit the use of assisted outpatient treatment (AOT), also called outpatient commitment. Ohio is one of those states.

All states recognize (and the Supreme Court has confirmed) that people who become a danger to themselves or others because of the symptoms of mental illness may be placed in inpatient care.ⁱⁱⁱ Many states, including Ohio, maintain

treatment standards based on criteria other than dangerousness. None of those statutes have been stricken down nor has the Supreme Court ruled them unconstitutional.^{iv} These standards encompass factors such as a deteriorating condition, need for treatment, ability to make informed treatment decisions, likelihood of becoming dangerous absent treatment, and the capability of independent functioning.^v

The fact that more and more states recognize the power of the state to act in the parens patriae (parent of the nation) role to help those “who have been rendered incapable of rational decision making or self-preservation by the effects of mental illness, is proof that the idea of dangerousness as the only justification for civil commitment no longer prevails.^{vi}

No federal court we are aware of has ever ruled parens patriae-based commitment criteria unconstitutional.^{vii} Multiple state supreme courts have unanimously upheld the constitutionality of parens patriae-based commitment criteria.^{viii}

Assisted outpatient treatment works

Assisted outpatient treatment is court-ordered treatment for individuals who meet specific criteria often including medication noncompliance, as a condition of their remaining in the community. Criteria for its use vary from state to state and include parens patriae criteria in many states. Studies and data from states using AOT, including Ohio, prove that it is effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance, while reducing caregiver stress.

While nearly every study of AOT has found at least one statistically significant and beneficial effect of the treatment tool, research is such that many studies have been used to “vociferously support any of the three positions: for, against, and undecided.”^{ix}

The most comprehensive, randomized control study of AOT, referred to as the “Duke Study,” involved people who “generally did not view themselves as mentally ill or in need of treatment.”^x The study compared people who were offered community mental health services with people who were offered the same services combined with a court order requiring participation in those services (i.e., the difference was the court order). The Duke Study showed that combining a court order with services for a long term (at least six months) reduced hospitalization (up to 74 percent), arrests (74 percent), violence (up to 50 percent), and victimization (43 percent) and improved treatment compliance (58 percent).^{xi}

The reason every state has some form of involuntary mental health treatment is because it is recognized that a significant subset of the population with the most severe mental illness is too ill to seek treatment voluntarily. These individuals often are experiencing “anosognosia” - impaired or lack of awareness of illness - an anatomical condition that affects the brain. The condition affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder and is believed to be the single largest reason why individuals with these illnesses do not take their medications.^{xii}

Rationale for support

We support SB 350 for the following reasons:

S.B. 350 clarifies language in the state's mental health treatment law.

- *The title under the current law, “mentally ill person subject to hospitalization by court order,” creates confusion as to whether outpatient commitment is permitted. S.B. 350 is needed to eliminate any question as to whether a court may order certain individuals with serious and persistent mental illness into outpatient treatment.*

S.B. 350 ensures a less restrictive – and a less costly – alternative to hospitalization.

- *S.B. 350 provides judges with clear authority to intervene before someone with a serious mental illness who is unaware of his or her need for treatment (i.e., suffers anosognosia) becomes so ill that hospitalization or incarceration are the only options remaining. While this authority already exists, SB 350 removes any confusion.*

S.B. 350 does not require any new programs or services – and will save money.

- *People who qualify for civil commitment under SB 350 criteria are already entitled to and use community services. The bill seeks clarity to ensure that these services may be court-ordered in the community to more effectively and efficiently provide care.*
- *S.B. 350 provides a tool that – where implemented – will reduce rates and incidents of hospitalization, victimization, homelessness, arrests and incarceration – and ultimately save the state money.*

4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.

Ohio's existing law is reasonable but confusing. SB 350 is necessary to strengthen and clarify the law.

The Treatment Advocacy Center recently published a guide for implementing AOT based on examination of a number of active AOT programs throughout the country. One of the sites we visited was Summit County, Ohio. Our experience searching for potential sites and the information we collected from our visit demonstrated that, while Ohio's law is used effectively in Summit County, it is not used at all in many other Ohio counties. Because of the confusion with the current law, many are not aware that it exists.

In Summit County, the effectiveness of AOT in decreasing hospital admissions was clearly established more than a decade ago when the county documented a decrease from 1.5 to 0.4 admissions per year before and after AOT.^{xiii} AOT also increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and attendance at day treatment sessions from 23 to 60 sessions per year.^{xiv}

A study conducted for the California Senate by the Rand Corp. that looked at AOT is sometimes used as a reference to demonstrate that outpatient commitment laws are ineffective.^{xv} Shortly after that study was published, the California legislature passed an assisted outpatient treatment law. While some use the study to justify AOT's failure, it showed multiple benefits of AOT in states who implemented their laws. The Rand study was published in 2002 and much research since that time has proven AOT to be an effective evidence based practice.^{xvi}

5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.

Not applicable.

6. If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify. Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

While we currently support SB 350, any amendments to the criteria in the bill would need to be examined to determine whether our support would continue.

Our understanding is that some have raised concerns that the revised fourth standard is broader than current language. We believe it is not. However, we would be happy to make recommendations to ensure clarity.

7. Please discuss any positive or negative ramifications you think SB 350 will have for the following:

- a. People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;

SB 350 and the existing Ohio civil commitment law seek to help get treatment to individuals who are unable to voluntarily access it.

The Treatment Advocacy Center supports recovery-based efforts where individuals are able to direct their own care. However, as one psychiatrist noted recently, "(t)he unfortunate irony of psychiatric care today is that oftentimes the patients who are most in need of services are too disorganized and ill to seek assistance themselves."^{xvii}

By adding clarity to the law, SB 350 will provide an opportunity to get help for people before they end up in a crisis situation that requires hospitalization or results in arrest or other consequences of non-treatment. The bill is not intended to cast a wider net with the changes it seeks.

SB 350 provides benefits to people with SPMI in the community because it highlights another less-restrictive tool available to effectively engage people in treatment. The law is not meant to be punitive, but rather provide

- b. Family members of people with SPMI;

The events that trigger the need for using mental health treatment laws are often harrowing and always stressful. Family members who care for those with untreated severe mental illnesses face tremendous burdens, both emotionally and financially.

Providing more clarity to Ohio's law will provide additional avenues to treatment and recovery for individuals suffering from untreated severe mental illness, especially those who suffer from lack of insight (anosognosia). SB 350 will provide more opportunities for people to get and stay well. This will reduce the suffering so many families face and reduce the impacts on the community that untreated severe mental illness exerts.

A study published in 2004 examined the impact of AOT on those who serve as primary caregivers for people with severe mental illness (typically, family members). The level of reported stress was compared for caregivers of individuals who received AOT of at least six months, those

who received brief AOT, and those who received no AOT. The results indicated that extended AOT (six months or more) significantly reduced caregiver stress. Not surprisingly, improved treatment adherence was also found to reduce caregiver stress. Notably, the study showed that AOT operates as an independent factor from treatment adherence in reducing stress. That is, AOT “contributes significantly to reduced caregiver strain, over and above its effect on treatment adherence”^{xviii}

c. Providers of services and supports for people with SPMI;

SB 350 brings clarity to the current law so that service and support providers will feel confident that court-ordered outpatient treatment is permissible.

d. Probate Judges and Courts;

The benefits to judges and courts are that SB 350 removes any ambiguity as to whether AOT is permitted. In addition, court events related to non-treatment are reduced due to the use of AOT (e.g., reduction in civil commitments related to hospitalizations).

SB 350 does not seek to broaden civil commitment criteria. The current “fourth” criterion provides that:

“a mentally ill person who, because of the person's illness . . . Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.”

That existing standard is broader and arguably more confusing than the language SB 350 recommend:

“The person would benefit from treatment due to all of the following:

- (a) The person is unlikely to voluntarily participate in treatment.*
- (b) The person has demonstrated difficulty in adhering to prescribed treatment.*
- (c) The likelihood that, if the person is not treated, the person's current condition will deteriorate to the point that the person will meet the criterion in one, two or three above.”*

We are aware of no state that has seen a significant increase in court activity after adopting, let alone revising, its outpatient commitment law. Outpatient commitment, when implemented, has proven to significantly reduce interactions with law enforcement (resulting in a reduction in criminal court cases) and hospitalization days and rates (i.e., fewer inpatient/emergency applications). As a result, the related court events

have also reduced. I am happy to provide statistics from other states with similar laws.

e. Law Enforcement Officers;

In Ohio, a person suffering from severe mental illness is four times more likely to be in jail or prison versus a psychiatric hospital^{xix}.

If outpatient commitment were implemented more broadly, law enforcement could see a significant reduction in arrests and incarceration of individuals with untreated severe mental illness. A substantial body of research conducted in diverse jurisdictions over more than two decades establishes the effectiveness of assisted outpatient treatment at reducing the risk of arrest, incarceration, crime, victimization, and violence.

In evidence, a 2010 study by Columbia University's Mailman School of Public Health found that, when AOT recipients in New York City and a control group of other mentally ill outpatients were tracked and compared, the AOT patients – despite having more violent histories – were four times less likely to perpetrate serious violence after undergoing court-ordered outpatient treatment (Phelan et al. 2010).

The Corrections Center of Northeast Ohio reported in 2009 that 25 percent of its inmates were on psychotropic medications; the cost of the drugs accounted for half of the medical budget. In the Lucas County Jail, 23 of the 24 inmates in the psychiatric unit were repeat offenders. Some examples of studies that demonstrate AOT reducing arrests:

- *According to a New York State Office of Mental Health 2005 report on Kendra's Law, arrests for AOT participants were reduced by 83 percent, plummeting from 30 percent prior to the onset of a court order to only 5 percent after participating in the program.^{xx}*
- *In a Florida report, AOT reduced days spent in jail among participants from 16.1 to 4.5 days, a 72 percent reduction.^{xxi}*
- *Similarly, the Duke study in North Carolina found that, for individuals who had a history of multiple hospital admissions combined with arrests and/or violence in the prior year, long-term AOT reduced the risk of arrest by 74 percent. The arrest rate for participants in long-term AOT was 12 percent, compared with 47 percent for those who had services without a court order.^{xxii}*

Given the effectiveness of these laws where implemented, Ohio should be looking at methods, like SB 350, to ensure that people suffering from

severe mental illness get treatment before they end up in your jails and prisons.

f. Other

8. Is there any additional information that you would like to share with us regarding your position on SB 350?
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ⁱ OHIO REV. CODE ANN. § 5122.01(B)

ⁱⁱ OHIO REV. CODE ANN. § 5122.01(B)(4) (“ (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.”)

ⁱⁱⁱ O’Connor, 422 U.S. at 575; see also Floyd L. Jennings, Current Status of Mental Health Commitments, 35 The Houston Lawyer 40, 40 (noting that discussion over past two decades has focused not on whether state can commit an individual with mental illness, but rather what procedural and substantive due process are necessary).

^{iv} Jeffrey Geller & Jonathan Stanley, 31 N.E. J. on Crim. & Civ. Con. 127 (2005);

^v Id; E.g., Ariz. Rev. Stat. 36-540 (A) (1999) (need for treatment); Idaho Code 66-339A(2) (1999) (likelihood of becoming dangerous without treatment); S.C. Code Ann. 44-17-580 (1976) (incapacity to make responsible decisions with respect to treatment); Wash. Rev. Code Ann. 71.05.020(14) (1998) (severe and escalating deterioration in routine functioning); Wis. Stat. Ann. 51.20(1)(a)(2) (2003) (will result in the loss of ability to function in community).

^{vi} Geller, supra note ii

^{vii} Geller, supra note ii

^{viii} E.g., In re Detention of LaBelle, 728 P.2d 138 (Wash. 1986); State of Wisconsin v. Dennis H., 647 N.W.2d 851 (Wisc. 2002); In re K.L., 806 N.E.2d 480 (N.Y. 2004)

^{ix} Geller, supra note ii; E.g., Swartz, Marvin S., Swanson, Jeffrey W., Steadman, Henry J., Robbins, Pamela Clark, and John Monahan. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine (2009) (AOT recipients were hospitalized at less than half the rate they were hospitalized in the six months prior to receiving AOT (i.e., the hospitalization rate dropped from 74 percent to 36 percent); New York State Office of Mental Health. 2005. Kendra’s Law: Final Report on the Status of Assisted Outpatient Treatment ((found that for those in the AOT program: 74 percent fewer experienced homelessness; 77 percent fewer experienced psychiatric hospitalization; 83 percent fewer experienced arrest; and 87 percent fewer experienced incarceration)); Marvin S. Swartz et al., Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?, 156 Am. J. Psychiatry 1968, 1973 (1999) (AOT reduced hospital admissions by fifty-seven percent when used for at least six months and combined with routine mental health services); Jeffrey W. Swanson et al., Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness, 176 Brit. J. Psychiatry 224, 228-29 (2000) (incidences of violence halved when AOT used for at least six months and combined with routine mental health services); Jeffrey W. Swanson et al., Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?, 28 Crim. Just. & Behav. 156, 182-83 (2001) (among those with history of multiple hospitalizations and arrests or violence, median re-arrest rate of those under AOT was approximately one-quarter (twelve versus forty-seven percent) of those who were not under AOT); Virginia A. Hiday et al., Impact of Outpatient Commitment on Victimization of People With Severe Mental Illness, 159 Am. J. Psychiatry 1403, 1411 (2002) (in one year, forty-two percent of those in the control group were victims of crimes such as rape, theft, mugging, or burglary, versus only twenty-four percent of those who were in assisted outpatient treatment for six months or more with routine services); Gustavo A. Fernandez & Sylvia Nygard, Impact of Involuntary

Outpatient Commitment on the Revolving-Door Syndrome in North Carolina, 41 *Hosp. & Cmty. Psychiatry* 1001, 1003 (1990) (median readmissions decrease from 3.7 to 0.7 per 1,000 days); Virginia A. Hiday & Teresa L. Scheid-Cook, The North Carolina Experience with Outpatient Commitment: A Critical Appraisal, 10 *Int'l J.L. & Psychiatry* 215, 229 (1987) (over six months, thirty percent medication refusal versus sixty-six percent absent orders); Robert A. Van Putten et al., Involuntary Outpatient Commitment in Arizona: A Retrospective Study, 39 *Hosp. & Cmty. Psychiatry* 953, 957 (1988) ("Almost no patients" without an order voluntarily maintain treatment in mental health system versus seventy-one percent who receive such an order); Guido Zanni & Leslie deVeau, Inpatient Stays Before and After Outpatient Commitment, 37 *Hosp. & Cmty. Psychiatry* 941, 942 (1986) (readmissions decrease from 1.81 to 0.95 per year).

^x Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A., Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156, 1968-75.

^{xi} Swartz, M.S., Swanson, J.W., Hiday, V.A., Wagner, H.R., Burns, B.J., Borum, R. (2001). A randomized controlled trial of outpatient commitment in North Carolina *Psychiatric Services*, 52, 325-9.; Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A., Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156, 1968-75; Swanson, J.W., Borum, R., Swartz, M.S., Hiday, V.A., Wagner, H.R., Burns, B.J. (2001). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? (2001). *Criminal Justice and Behavior*, 28, 156-89.; Swanson, J.W., Borum, R., Swartz, M.S., Hiday, V.A., Wagner, H.R., Burns, B.J. (2000). Involuntary outpatient commitment and reduction of violent behaviour in persons with severe mental illness. *Brit. J. Psychiatry*, 176, 324-31; Hiday, V.A., Swartz, M.S., Swanson, J.W., Borum, R., Wagner, H.R. (2002). Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry*, 159, 1403-11; Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A. (2001). Effects of involuntary outpatient commitment and depot antipsychotics on treatment adherence in persons with severe mental illness. *J. Nerv. and Mental Diseases*, 189, 583-92. **Tab 12**

^{xii} Treatment Advocacy Center. "Anosognosia"

<http://www.treatmentadvocacycenter.org/problem/anosognosia> (visited November 2012)

^{xiii} Munetz, Mark R., Grande, Thomas, Kleist, Jeffrey, and Gregory A. Peterson. 1996. "The Effectiveness of Outpatient Civil Commitment." *Psychiatric Services* 47: 1251-1253

^{xiv} Id.

^{xv} The Effectiveness of Involuntary Outpatient *Treatment: Empirical Evidence and the Experience of Eight States.* (Rand Corporation, 2002).

^{xvi} Office of Justice Programs, crime solutions designation.

<http://www.crimesolutions.gov/ProgramDetails.aspx?ID=228>

^{xvii} Tsai, Gary. "Assisted outpatient treatment: Preventative, recovery-based care for the most seriously mentally ill." *The Residents' Journal*, June 2012.

^{xviii} Groff, April, Burns, Barbara, Swanson, Jeffrey, Swartz, Marvin, Wagner, H. Ryan, and Martha Tompson. 2004. "Caregiving for Persons with Mental Illness: The Impact of Outpatient Commitment on Caregiving Strain." *Journal of Nervous and Mental Disease* 192: 554-562.

^{xix} Torrey, Fuller et al., "More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States" (Treatment Advocacy Center and the National Sheriffs' Association, May 2010)

^{xx} New York State Office of Mental Health. 2005. *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* (found that for those in the AOT program: 74 percent fewer experienced homelessness; 77 percent fewer experienced psychiatric hospitalization; 83 percent fewer experienced arrest; and 87 percent fewer experienced incarceration)

^{xxi} Esposito, Rosanna, Westhead, Valerie, and Jim Berko. 2008. "Florida's Outpatient Commitment Law: Effective but Underused" (letter). *Psychiatric Services* 59: 328.

^{xxii} Swanson et al., supra note xi

Kristina Ragosta – Treatment Advocacy Center (TAC) Phone Testimony

If you cannot force a mentally ill person to take medications, how will AOT or APO or any legislation help with recovery if medication is not forced to take medication to Recovery?

That's a common question that comes up a lot in every state not just Ohio but in every state that is looking to implement laws. The bottom line is that these types of laws have been shown to significantly increase treatment compliance so while there may be instances where someone that is under a Court Order Community Treatment and does not comply with the treatment plan. I think you will find and studies have found that is less likely to happen when someone is under a Court Order and I think one of the reasons for that is people with severe mental illness like you and I want to follow the law when the black robe effect term is commonly used. When we are talking about outpatient commitment and in New York the first five years of New York using their outpatient commitment law they saw among participants treatment compliance increase by 103% and that's common those types of numbers. This law is not about forcible medication that happens in a hospital in a licensed facility. In almost every state there are typically process and protocols in place for non-compliance which will allow you to if someone begins to deteriorate that's under an order of outpatient commitment will allow you to intervene and bring that person in for an evaluation typically depending on the state's compliance provision but this law is not about forced medication and I don't feel it needs to be.

We heard testimony earlier today that suggested that removing the term “hospitalization” from the definition of “mentally ill person subject to hospitalization by Court Order” could create a barrier in actually receiving hospital level of care. Would you agree?

You know I have never heard that concern raised and I would certainly hope not if a person is not stable enough to be able to obtain the standard of care would seem to dictate otherwise and that was certainly not the intention of this bill. With that said Ohio like every state in the country is facing a bed shortage, a psychiatric bed shortage the intent of outpatient commitment and one of the goals is to provide support for individuals who are well enough to be in the community to ensure compliance. So I have never heard that concern raised regarding this bill but I would be interested to know the rationale behind that. Another aspect to that if I may, given what I understand is the process that's used in Ohio in communities and counties that implement the law currently you know I would think that this shouldn't be a concern because the person is committed to the ADM Board that has oversight over the care and treatment. So I would imagine that this shouldn't be an issue and I think if I saw it correctly Dr. Mark Munetz is testifying at some point today and he would probably be better able to answer that question.

Dr. Mark Munetz – Ohio Psychiatric Physicians Associations – Phone Testimony

In Summit County, what happens when someone under court ordered outpatient treatment does not follow their treatment plan?

The consequence of not following the treatment plan is not immediate. Not complying with treatment by itself is not grounds for action as we have implemented assisted outpatient treatment in Summit County. If someone while be observed on a court ordered outpatient treatment begins to demonstrate changes in behavior that are consistent with the previously established pattern of decompensating rather than waiting until the person had decompensated to the point of immediate danger to themselves or others. If they are on a commitment order as an outpatient in Summit County the treating psychiatrist can request of the Court what we call a court ordered evaluation in which the person could be picked up by a county Sheriff Deputy and brought to a crisis center for evaluation but that's only a result of change in behavior not simply for noncompliance with the treatment plan.

Has Summit County Probate Court ever considered finding someone in contempt of Court and placed in Jail?

No, Summit County Probate Court to my knowledge has never issued a contempt order.

What processes were established in Summit County in 1990 going forward, that promoted the use of the current outpatient commitment law?

I can tell you what we have done, its harder to answer why other counties haven't done it. I think part of that answer is based on how Probate Court Judges have interpreted the current law and how other communities have felt about the process. In Summit County going back to the early 90's it actually preceded my time in the community, there were regular meetings between the stakeholders in the commitment process so the Magistrate from the Probate Court the attorneys representing the board at the Civil Commitment Hearings. The Clinical leaders at the board and at the provider agencies in the County were meeting regularly and were looking at how to most effectively serve the population particularly those with serious and persistent mental illness to foster their ability to live successfully in the community. Frankly there was a big push at that time to reduce the utilization of the State Psychiatric Hospitals. There was fairly good consensus among those individuals at that time that the law was congruent with assisted outpatient or outpatient civil commitment and we talked about it and we had a consultation from the State Department of Mental Health, the Ohio Legal Rights Service who had strong feelings that this was not the right way to go. We got their input and others and essentially developed guidelines on how to use the law as written to establish an assisted outpatient treatment program so I think it was the fact that everybody was more or less on the same page believing that the outcome was going to be positive for the patients we were trying to help with serious mental illness. Other communities don't seem to have that consensus and I can't really state why although I think in fairness the current statute is challenging to read and understand and it's not surprising that different Judges and different mental health professionals and administrators have interpreted it differently. This

is why I and OPBA support senate bill 350 because we think it's going to clean up the language and make it very clear that this is doable.

Do you feel that local NAMI's family members should bring their concerns to the local ADAMH Boards as a starting point?

Yes, I'm not exactly sure how that connects to senate bill 350 but yes my experience is that the boards want to hear family members and other consumers and advocates about what's working and what's not working in the system so encourage that

Can you provide us with the success rate of outpatient treatment In Summit County?

We have done studies on a couple of occasions that demonstrate substantial decreases in rates of hospitalization and re-hospitalization of both days in hospital and time in hospital for people committed to the board versus essentially comparing themselves absent themselves to the Court Order. It's clearly not an intervention that works for everyone and there are people who or for whom it hasn't been effective and I don't know that I can give you a percentage of who it has been successful for and who it has not. I don't think I have that kind of data at my fingertips.

Can you tell us the cost for outpatient treatments in Summit County?

The cost in Summit County this program was initiated in the early 90's and has continued without it really being a special program. If you will it's just one tool that is available to the mental health system so I don't know that I have a calculation of the cost just the treatment is provided for the people who need treatment as it would have been absent the Court Order. There is not a specialized treatment team for example for people on court ordered outpatient treatment. Obviously, there are court costs associated but I don't know that a calculation has been done to show that the courts more active using outpatient commitment. I think they really are having fewer inpatient commitment hearings as a result of this program. We have done some work looking at the overall cost versus benefits of this program which we hope at some point to be able to have it in a form that we can publish but overall because of the reduced hospitalization using assisted outpatient treatment saves money it doesn't cost money. The biggest savings being in terms of inpatient hospitalization care which is obviously the most expensive thing that we do.

We heard testimony earlier today that suggested that removing the term "hospitalization" from the definition of "mentally ill person subject to hospitalization by Court Order" and could create a barrier in actually receiving hospital level of care, would you agree?

I think I disagree with that I think the point of removing the term hospitalization is so that it is really clear that the level of intervention is consistent with the needs of the individual and is the least restrictive alternative. If an individual needs to be hospitalized that option is obviously still available and I don't the change in the wording of the statement would effect if.

I will say that I went around the state for a long time trying to encourage other counties to do what we did in Summitt County so for some time. Some of the people who are opposed to senate bill 350 are

taking now that there is no need to change the statutes and this is already doable but after 20 years a little more than 20 years it became clear to me that there were obvious reasons why other counties weren't doing what Summitt County was doing and those reasons seem to be the complexity and the lack of clarity in the law. I changed my opinion and I think it's a very good idea to actually modify the statute as proposed so that this kind of program can be available statewide.

Questions for Key Stakeholders

What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)

My name is Kristen Herrmann. The National Alliance on Mental Illness (NAMI) of Franklin County has asked me to give stakeholder input in support of SB 350. I am a former member of NAMI of Franklin County's Board of Directors, a member of the Advocacy Committee, and recipient of The Dr. Bernie Kuhr Going The Extra Mile Award in 2011. But, I am speaking here today as a concerned citizen and mental health consumer.

Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.

I am Severely and Persistently Mentally Ill (SPMI). I have Schizoaffective Disorder, which simply means I have both Schizophrenia and Bi Polar Disorder at the same time. I am 48, and have had a diagnosed mental illness since the age of 13. I have a history of going off my medications, and as a direct result of my untreated mental illness, I have had 2 brushes with law enforcement, and so many hospitalizations that I can't tally them all up, but I am sure they number well over 100. I support SB 350 because when I am not able to recognize my need for treatment, my treatment team, family, and friends will be able to use Court Ordered Outpatient Treatment to get me treatment before I totally deteriorate.

State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.

I want SB 350. No, I need SB 350. I need it to keep me safe, when I am not able to do that for myself. I believe we very much need SB 350. The statute as it currently reads is vague and open to interpretation. I am assuming this is why so few people have been placed on Court Ordered Outpatient Commitment, and few people even know of the existence of the statute I think the current statute just needs to be "beefed up" and clarified so that judges will feel more confident and comfortable placing a person on Court Ordered Outpatient Treatment. They will know exactly what the process is and what will happen to the mentally ill person. We also need to get the word out to mental health care providers, the families, and friends of those us who are mentally ill, and who repeatedly do not comply with our medication and treatment plan, that now there is a

way to help us get the treatment we so desperately need, even though at the time we may say we don't need it. I have been on a monitored treatment program in the past, and at the beginning, I was not happy to be on it, but after the fact, I am grateful I was.

AOT stands for Assisted Outpatient Treatment, which is basically the same as what SB 350 is calling Court Ordered Outpatient Therapy.

As the studies have shown: In New York, under Kendra's Law, research has documented the following statistics gathered from interviews with recipients of the treatment. They overwhelmingly endorse the program:

- **75 percent reported that AOT helped them gain control over their lives.**
- **81 percent said that AOT helped them to get and stay well.**
- **90 percent said AOT made them more likely to keep appointments and take medication.**
- **87 percent were confident in their case manager's ability to help them.**

There is also a condition called anosognosa, where the person does not and cannot comprehend that they are ill. It is not denial; a part of their brain is not functioning normally. Anosognosa affects about 50 to 60 percent of people with Schizophrenia. Court Ordered Outpatient Treatment, would assist these people to remain on medication and in treatment, even though they do not believe that are ill and need it.

The following statistics are based on the collection of independent research and data by The Treatment Advocacy Center:

AOT improves treatment compliance—In New York, the number of individuals exhibiting good service engagement increased by 51% and the number of individuals exhibiting good adherence to medication increased by 103%

AOT reduces hospitalization—77% experienced fewer hospitalizations. This is a critically important figure when hospital beds are so scarce, and expensive.

AOT reduces victimization—The North Carolina study found that individuals with severe psychiatric illnesses who were not on AOT were almost twice as likely to be victimized as were outpatient commitment subjects.

AOT improves substance abuse treatment—49% fewer abused alcohol and 48% fewer abused drugs.

Kristen Herrmann – Consumer Proponent

No Questions

Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.

Though I have never had an official Ohio Court Ordered Outpatient Commitment, for all intents and purposes I have. In an out of court plea agreement, I was subject to a lot of the same aspects of Court Ordered Outpatient Commitment. I had a treatment plan I had to follow which included meeting with a Community Mental Health Center case manager on a regular basis, attending all appointments with my psychiatrist, and taking medication as prescribed. I have a history of repeatedly stopping taking my medication. Each and every one of those instances ended in a hospital stay or worse. When I stop taking my medication, I after a while I start to have my symptoms return. From there, I go downhill and eventually become a danger to myself or others. I have been told by my family and friends, that they feel helpless, frustrated, and angry when they see me deteriorating, but there is nothing they can do to stop me from becoming an imminent threat to myself or others. If Court Ordered Outpatient Treatment, as per SB 350 was in place, my family and friends would have had an option to help me. For me, my Schizophrenia and Bi Polar Disorder are only treatable by taking medication. Because Court Ordered Outpatient Treatment, allows a mentally ill person who has a history of non compliance to be compelled to take medication, they could have gone to the court and explained, although I was not an imminent threat, I would become so in the future if I did not restart taking my medication again. The details of my monitored treatment program had many of the same aspects of Court Ordered Outpatient Commitment. I was expected to keep weekly appointments with my psychiatrist, and 3 times per week meetings with my case manager. Sometimes I was subject to a pill count where my pills were counted to make sure I had taken them, sometimes he would show up at my apartment at med time, and I was required to take my medication in front of him. I was also subjected to random blood tests to verify my Lithium level, thus showing if I was taking it regularly. I was also told I had to get rid of some items I had. For example 1 CD I had triggered some violent delusions. My case manager confiscated that CD, and I was expected to not purchase another one. Also some of my art work was taken to a friend's home for storage, because the paintings fed into my delusions. I was expected to take all medication as prescribed by my psychiatrist, and family doctor. I also was forbidden to associate with some family and friends who were not good for me. So what happened if I did not do these things and comply with all the other aspects of my treatment plan? I was evaluated in a joint session involving my psychiatrist, my case manager and a member of the law enforcement agency that had been involved with my case. At that time I was given a choice to come back into and maintain compliance with my treatment plan, or I would be placed into a psychiatric hospital until I was able and willing to comply with my the treatment plan. The team made sure I was an integral part of

developing my treatment program, SB 350 also allows, and specifically mentions that the mentally ill person must be involved in the creation of their treatment program. This is a good thing. But, I must also note that at the point someone is ill enough to be placed on Court Ordered Outpatient Treatment, they may be limited in the beginning as to how much that they are able to participate in the creation of the treatment program because of their illness. But to protect the mentally ill person's participation, SB 350 allows for monthly reviews, so that as the person improves the team can adjust the treatment plan accordingly. My monitored treatment program was implemented in 1993 and lasted for about 3 years. If instead of a monitored treatment program I had been incarcerated, according to the Vera Institute of Justice in 2010 the cost of incarceration per year in Ohio was \$25,814.00. From 1993 until now is 19 years. That would have cost the taxpayer's \$490,466.00. And as I assume I will live to be 80, which is another 32 years the taxpayer's could have expected pay an additional \$826,048.00. Instead, for the last 16 years the tax payers have paid zero dollars for me because I have worked full time in a professional capacity and have been able to pay for all my living and medical expenses on my own.

If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.

I do not oppose SB 350.

If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.

I support SB 350 as written

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

I support SB 350 as written.

Please discuss any positive or negative ramifications you think SB 350 will have for the following:

- a. **People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;**
- b. **Family members of people with SPMI;**
- c. **Providers of services and supports for people with SPMI;**
- d. **Probate Judges and Courts;**
- e. **Law Enforcement Officers;**
- f. **Other**

I think family members and mental health care providers will greatly benefit by the bill, as right now they are helpless until the patient hits rock bottom. Right now they can do nothing but watch the person slide downhill into a world that revolves around hallucinations and delusions, and to be helpless to do anything to stop it. By asking my friends and family members how they felt when they could see that I was out of treatment and going downhill. They universally said they felt frustrated and helpless. I think SB 350 gives hope to those family members and mental health care providers that this time can be different. About 4 years ago a mentally ill man shot and wounded a police officer, later in the exchange, he was killed. For weeks prior to this incident, his mother had been trying to get help for her mentally ill son who had a gun. He was not taking his medication and he was becoming disturbed and violent, and she knew from her experience he was going to continue to descend into madness. Because he did not meet the criteria of being an imminent danger to self or others, everywhere his mother turned, she was told there were no options; she had to just let her son deteriorate until he did meet the criteria for imminent danger. If SB 350 was in effect at that time, she would have been able to get help for her son and the entire tragedy may never have happened. SB 350 strengthens and clarifies the existing law. I think this will give judges the confidence and opportunity to get treatment for people who need it before they end up in the legal arena for some act they have done as a direct result of their illness. It also gives law enforcement officers an alternative to taking a mentally ill offender to the jail instead they can take them to a mental health crisis facility for treatment. If we can keep the chronically mentally ill out of the legal and incarceration system, everybody wins. As it takes far less money to have someone treated in the community, then locked up in jail.

The following statistics come from The Treatment and Advocacy Center about AOT, stands for Assisted Outpatient Therapy, which is basically the same as Court Ordered Outpatient Therapy in SB 350.

The following statistics are based on the collection of independent research and data by The Treatment Advocacy Center:

AOT reduces homelessness—74% fewer AOT recipients experience homelessness.

AOT reduces arrests—arrests for New York AOT recipients were reduced by 83%. Another critical statistic when we consider the high taxpayer cost for incarceration.

According to a letter written by Butler County Ohio Probate Judge, Randy Rogers, "In a free society, persons in dire need of mental health treatment should not have to be arrested in order to obtain the treatment they need."

AOT reduces violence—55% fewer recipients engaged in suicide attempts or physical harm to self; 47% fewer physically harmed others; 46% fewer damaged or destroyed property; and 43% fewer threatened physical harm to others.

Is there any additional information that you would like to share with us regarding your position on SB 350?

Today, I lead a relatively normal life. I am happily married and am working full time in a professional capacity. Having SB 350 on the books would allow people like me to get and remain in treatment even when we believe we don't need it. I wish that in the beginning of my mental illness there had been something like Court Ordered Outpatient Treatment. I suffered on and off from my mental illnesses for 35 years. I have used an outrageous amount of taxpayer money in crisis services and unneeded hospitalizations all because I did not take my medication and comply with my treatment program, and no one could make me. Well now with SB 350, someone can make me, and I will be better off in the long run.

Marc Baumgarten – Ohio Department of Mental Health

What would you say to a family that beg for commitment for over 4 months and that their child ultimately ran into traffic and was killed? AOT could have saved his life.

That's a very difficult question to answer, I understand and certainly sympathize with anybody facing that situation. The balance that is difficult to strike here is one of ensuring that if we were going to pass legislation like this is that it passes constitutional muster so that we can get people into treatment that need to be in treatment. One of the items I mentioned in testimony is looking at other states similar experiences for example New York State their statute is similar in structure in terms of trying to get individuals into treatment who may not meet in patient criteria that is not presently danger to themselves or others but have the potentiality to do so but in their statute they detail a list of criteria that an individual has to meet short of just saying they are likely not to continue treatment so I would say obviously the goal I would think is to try to get everybody into treatment that needs treatment and to try and make that statewide but at the same time I am sure that if we are going to pass legislation that it doesn't fail constitutionally so that we can get these people help.

Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB350 – Mandatory Outpatient Treatment Testimony

Responses to the questions for key stakeholders

1. Lieutenant Ryan C. Kidwell, representing the Buckeye State Sheriff's Association currently serving as a committee member of the Community Corrections Committee
2. My role as a key stakeholder and interest in SB 350, Court-Ordered Outpatient Treatment includes overseeing the administration and operations of the Sheriff's local county jail. Over the course of the past several years we have observed a continual increase of those who become incarcerated with mental health illness. We believe that the local county jail is not a setting which should be considered the least restrictive alternative in helping a person with mental health illness on a path to recovery. We believe those with mental health illness would be best served through outpatient treatment services.
3. The Buckeye State Sheriff's Association supports SB 350 with amendments. Ohio Revised Code 5122.15 (15) (C) (6) should be amended to state: "Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment need of the respondent. A correctional facility and/or jail for this section of the law is not to be considered a suitable facility". We find that local county jails typically have very limited resources and services in working with and treating individuals who become incarcerated that have a mental health illness. These findings are based on the fact that the local county jails main focus of operation is for the safety and security of the facility in detaining individuals charged with crimes who are either awaiting court proceedings or who have been convicted and sentenced to serve time in the local county jail.
4. The Buckeye State Sheriff's Association position regarding the existing Court-Ordered Outpatient Commitment law is that current law contains conflicting and confusing language which is left for judicial interpretation in determining what the least restrictive alternative available is that is consistent with treatment goals. We believe court ordered outpatient treatment is the least restrictive alternative and should be made available and used as an option, where appropriate. SB350 is needed to further clarify outpatient treatment goals, and objectives. We currently do not have any examples to use as direct experiences as they relate to the local county jail.
5. The Buckeye State Sheriff's Association does not oppose SB350.

6. The Buckeye State Sheriff's Association supports SB 350 with amendments. Ohio Revised Code 5122.15 (15) (C) (6) should be amended to state: "Any other suitable facility or person consistent with the diagnosis, prognosis, and treatment need of the respondent. A correctional facility and/or jail for this section of the law is not to be considered a suitable facility".
7. The Buckeye State Sheriff's Association believes SB350 will have positive outcomes for the following:
 - a. For people with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community will allow for court ordered outpatient treatment especially for those who are too ill to recognize their need for treatment or who refuse treatment, creating imminent risk to the substantial rights of themselves or others. Ultimately this will divert those with mental illness from the potential for incarceration and/or returning to inpatient treatment. SB350 will help individuals to continue mental health illness treatment in becoming productive, active members of the community.
 - b. For the family member of people with SPMI, SB 350 makes it easier for families to locate the affidavit form that already exists and is necessary to file with the probate court when the family member has probable cause to believe their loved one is in need of court ordered treatment.
 - c. Providers of services and supports for people with SPMI would allow for the availability and use of existing mental health services for those who are most ill. Currently individuals who meet court ordered outpatient treatment criteria are already receiving costly and inefficient service. These individuals are cycling in and out of emergency rooms and state hospitals and are often frequent users of the local county jails and state prison system.
 - d. Probate Judges and Courts would be focused on the importance of outpatient treatment in improving access and adherence to intensive treatment for high risk individuals (including those at risk for repeated hospitalizations, arrest, incarceration, violent behavior, homelessness or suicide) in the least restrictive setting and to help put them on a path to recovery
 - e. Law Enforcement Officers would have a reduced need to take action thus lessening the trauma and anguish of family and friends. Court Ordered outpatient treatment helps individuals who are too ill to recognize their need for treatment or refuse treatment, and create imminent risk to the substantial rights of themselves or others thus lessening the probability of a Law Enforcement encounter.
 - f. Other = Nothing additional to provide testimony

8. The Buckeye State Sheriff's Association has no additional information to share regarding its position on SB350.

Lieutenant Kidwell –Representing Buckeye State Sheriff’s Association (BSSA)

Moderator: Does the BSSA support increased funding to support more community mental health services to go along with the bill?

Lieutenant Kidwell: BSSA would support additional funding to go along with the bill.

Moderator: What is the BSSA’s position on the legal standard to find someone mentally ill?

Lieutenant Kidwell: asks for the question to be repeated

Moderator: if you could give clarification please (to person asking question)

Person asking question: I just mean with respect to the proposal I understand...the clarifying purpose of the bill to clarify the least restrictive setting. I can’t remember the B 4 section the...5122...

Other speaker: B 4

Person asking question: yeah B 4 of, yeah the bill would change the standards of how you find someone mentally ill to be eligible for hospitalization or outpatient services. But there is a slight change to talk a bit more about risk of future harm to one’s self or others...I don’t know if you guys took a close look at that or have the expertise to comment

Lieutenant Kidwell: We certainly did brief the bill in its entirety. With B 4 or anything else that wasn’t mentioned in my testimony we felt that as it is written it meets what we would support.

Moderator: The next question has to do with the affidavit you mentioned, do you think that Law Enforcement officers should carry the affidavit form in their paperwork for immediate access to the form for a family member to fill out?

Lieutenant Kidwell: I think any additional availability that we can provide back to the community as servants of the community, absolutely I think we could support that.

Moderator: Not a clarifying question, but I will ask it because it feels like a relatively neutral question for SB 350...Lt. Kidwell you participated in CIT training recently, do you believe you should continue offering these trainings to avoid serious consequences?

Lieutenant Kidwell: I fully support Crisis Intervention Training for all law enforcement, correctional, dispatchers...anybody associated with community...absolutely support it 100%.

****End of Testimony****

Criminal Justice – Mental Illness Task Force

Psychiatry and Treatment Sub-Committee

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

Ohio Chapter: American Psychiatric Nurses Association

Questions for Key Stakeholders

Good morning, and thank you for the opportunity to provide input on SB 350 on behalf of the Ohio Chapter of the American Psychiatric Nurses Association. My name is Jeanne Clement, and I am here today representing the Ohio Chapter of the American Psychiatric Nurses Association (APNA-OH). I am a Chapter member and past-President of both the Ohio Chapter and the national association.

APNA-OH, (see 12/6/12)

The ~~the~~ consideration of Court Ordered Outpatient Treatment is framed by two documents that guide the practice of psychiatric mental health nursing, The Code of Ethics for Nurses and the Scope and Standards of Psychiatric-Mental Health Nursing Practice. The APNA-OH believes that treatment for persons with psychiatric diagnoses requires the recognition of individual rights to self-determination and autonomy and also recognizes that there are situations in which these rights may be outweighed or limited by the rights, health and welfare of others, particularly in relation to public health concerns.

The Chapter believes court ordered outpatient treatment is a useful point on the continuum of treatment that, when needed, permits the individual to receive services in the least restrictive and most appropriate setting. The usefulness of court ordered outpatient depends first of all on the knowledge that stakeholders have about existence of the law. Also necessary is the availability of services that are guided by a comprehensive treatment plan and, if present, the individuals Advanced Directive for Mental Health Care. A treatment team must be responsible to provide and oversee the treatment. Treating practitioners and others involved must be subject to oversight in order to protect the rights of the patient receiving the court ordered treatment.

Given that Ohio already has legislation in place for Court-Ordered Outpatient Do you believe that SB 350 is needed? Why or why not?

Existing Ohio law, in place since the late 1980s, allows court-ordered outpatient treatment, however the language speaks specifically to court ordered hospitalization and it is not clear that less restrictive choices are available. This lack of clarity may be why so few jurisdictions, with a few outstanding examples, have chosen to apply court ordered treatment in community settings. SB 350 provides language that speaks to these deficits. The Chapter members support the Bill but have some concerns about how or if these changes will promote increased use of this treatment choice.

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify

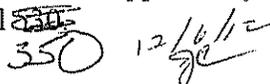
Despite the clarification of the language in the bill, some courts, as well as people with psychiatric diagnoses, families, treatment providers and other stakeholders may not benefit unless they have access to education concerning;

- a. knowledge of the existence of such legislation,
- b. how to use the information in the best interest of the person with the psychiatric diagnosis,
- c. what a viable treatment plan would look like, and who is involved in the development of the plan.
- d. the existence and use of Advanced Directives for Psychiatric Care, and
- e. what constitutes an appropriate community treatment setting. (Note: An example of an inappropriate setting may be confinement of the individual in a Nursing Home).

Please discuss any positive or negative ramifications you think SB 350 will have for the following:

It is possible that the changes proposed in SB 530, clarifying and more clearly defining the role of court ordered community treatment, may not produce any change in the way commitment is handled in most Ohio jurisdictions. Without the marketing needed to promote and explain the appropriate application of these changes to stakeholder groups, change is unlikely. If appropriate dissemination of the use of the law to all, including persons with psychiatric diagnoses through State and county based consumer run services and other organizations, the change has the potential to help provide needed services in least restrictive settings that are respectful of the dignity of all stakeholders and promote recovery.

I thank you for the opportunity for psychiatric nurses to provide their perspective on House Bill ~~530~~

350 12/6/12


Jeanne Clement-Representing the Ohio Chapter of Psychiatric Nurses Association

Moderator: In your opinion, would this bill be effective without additional resources given to community mental health systems?

Jeanne Clement: I think it would depend on the county or jurisdiction this takes place. I think availability of services differ around the state in terms of available services and people providing those services. I think it's a very different question to answer but I'm going to say yes, it would be nice to have additional resources, but as it's written I don't believe it has additional resources. I do believe how resources are allocated...the education that needs to go along with this to help people know what it is and how to use it may need some additional resources but it is not in the bill currently.

Moderator: Are you concerned with the bill's proposed changes to the legal standard to find someone mentally ill?

Jeanne Clement: I have some concerns that the changes may... this is really strengthening it, but if it changes the standard for hospital commitments which is the most restrictive form of treatment and changes the criteria for that hospitalization...I would be worried about that.

Two speaker's unrecognizable conversation

Jeanne Clement: I think it's a definition that speaks to people who would benefit from community treatment and maybe people that would otherwise be hospitalized...that community treatment would be more beneficial and I think how it plays out in practice would be more interesting thing in how it's actually applied.

Moderator: Do you think there is a potential to save money treating people in least restrictive settings?

Jeanne Clement: I think there is an incredible potential to save money ...the gentleman from BSSA hit upon some of the ways in the criminal justice system that money could be saved. I think money could be saved in many ways by helping people be maintained in the community as opposed to in a hospital setting where the cost in the long run is more to both fiscal resources and human resources. I think being in the most appropriate setting with the most appropriate treatment that is a mutually decided plan of care, not written by someone in a treatment facility and told to family or individual but for them to have input into it. That's why I spoke to advantages of using advance directives for psychiatric care which statute has also been in law since the Taft administration which we have not generally had widespread use.

****End of Testimony****

**Criminal Justice – Mental Illness Task Force
Psychiatry and Treatment Sub-Committee**

Key Stakeholder SB 350 - Mandatory Outpatient Treatment Testimony

Questions for Key Stakeholders

- 1. What is your Name? Do you represent an organization (association)? If organization, state the name of your organization and your position with this organization. (Note: If you represent an organization, all questions below are to be answered regarding your organization's positions and recommendations.)**

My name is Patrick Risser. I do not formally represent any organization or association in this testimony. However, I am a member of many organizations/associations including the SAMHSA/CMHS National Advisory Council, the Board of Directors of NARPA (National Association for Rights Protection and Advocacy), the Board of Directors of Witness Justice (whose mission is to empower and assist victims of violence and their loved ones in healing from trauma and in navigating the criminal justice process), Ohio Empowerment Coalition, Chair of the Ohio Community Support Planning Council, and Lifework Peer Recovery Center in Ashland, Ohio, just to name a few of my many involvements. I am also husband, father, grandfather, friend, neighbor, family member, home-owner, tax payer and registered voter. I am active in my community, local, state and national.

To speak to my credibility on this issue, I've worked for over thirty years as an activist/advocate and I have been recognized as Case Manager of the year by the National Association of Case Management, by the National Mental Health Association with their highest award, the Clifford Beers Award for a lifetime of work training my peers in recovery and by SAMHSA with a Voice Award for a lifetime of helping people overcome trauma and find their own voice through recovery and empowerment.

- 2. Describe your role as a key stakeholder with interest in SB 350, Court-Ordered Outpatient Treatment.**

I am a person with lived experience with psychiatric issues. I have been hospitalized over twenty times including state hospital and most of those hospitalizations were involuntary civil commitments. I have recovered and not been hospitalized or needed care or treatment in over twenty years. I've worked as a mental health professional (intensive case manager and therapist on a locked acute inpatient unit) and as a legal advocate representing the interests of people with psychiatric issues in hundreds (perhaps thousands) of cases. I currently teach recovery and empowerment to others and have done so for nearly thirty years. I consider myself an advocate for people with disabilities.

I believe non-compliance literally saved my life. I spent over ten years of my life as a "compliant" mental patient. I have survived five heart attacks and I believe those heart problems were a "side-effect" of many years of compliance with psychiatric medications. One time, while in state hospital, I was desperately suicidal. I figured that the easiest way to commit suicide was to stop taking all my medications, including my heart medicine. I got better almost immediately. There are numerous studies now that have demonstrated a clear link between suicidal and homicidal behavior and certain psychiatric medications. Also, I got better because the major

listed "side-effect" of Inderal (a beta blocker for my heart) is major depression. Not one doctor (psychiatrist) made this connection. Had I continued to be compliant, I am convinced that I'd have deteriorated to the point where I'd have found a way to successfully suicide.

Like many of my peers, I rebelled against authority. I might have been considered by the proponents of this legislation to have been an ideal candidate for the use of Court-Ordered Outpatient Treatment. It would have been the equivalent of a death sentence. We now know that as of 2007, "Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years." What does it mean that the life expectancy of persons with serious mental illness in the United States is now shortening, in the context of longer life expectancy among others in our society? It is evidence of the gravest form of disparity and discrimination. SB350 is further discrimination and could impose a potential death sentence upon people.

SB350 presumes failure to comply with medications and failure to participate in treatment is somehow the fault of those who may require or seek treatment. However, factual reality would indicate that the failure is actually due to the system being in shambles and broken. SB350 does nothing to address this brokenness of the system and in fact blames the victim.

3. State your position on SB 350, Court-Ordered Outpatient Treatment and the rationale and factors that have established your position.

I am opposed to SB350 for several reasons:

Broadly speaking, the arguments against outpatient commitment claim that it undermines the therapeutic relationship, minimizes incentives for compliance, deprives the patient of the right to refuse treatment, has a broad range of activities to be monitored, lowers the standard for state intervention, and that benevolent coercion is generally futile. The primary argument currently against outpatient commitment is that it unjustifiably and unnecessarily extends the social control function of the mental health system. This is particularly the case when outpatient commitment is used for preventive detention, a commitment criteria based on standards less stringent than civil commitment to hospitalization.

Outpatient commitment is not a treatment in the sense that a particular psychotropic medication or a form of cognitive or behavioral therapy is a treatment. There is no consensus about what outpatient commitment means, in terms either of a legal definition or of a treatment regimen. Indeed, there is no agreement about what it is supposed to accomplish. The lack of agreement makes it difficult to engage in meaningful discussion about whether outpatient commitment works and whether it violates the right of persons with mental illness to some level of autonomy.

Commitment is a preventive measure, and as such it raises only a single constitutional or policy issue: how likely must the future harm be in order to justify what the courts have regularly—and correctly—described as a massive curtailment of liberty?

It creates an "adversarial" relationship with the person being coerced. Studies have shown force and coercion do not work and in fact do the opposite by

pushing away people who might otherwise seek voluntary treatment. The use of force and coercion are always **traumatizing or retraumatizing** which creates additional problems including precluding any future potential for a therapeutic alliance. Rather, it undermines the therapeutic relationship and leads to alienation from treatment. It is of dubious ethics because individuals are duped into complying with nonenforceable court orders. Ultimately, OPC does not improve quality of life. **IOC's use of coercion risks driving people away from treatment** as they lose trust in the people and the systems those people represent (Campbell & Schraiber, 1989). It re-traumatizes clients who already have a high prevalence of trauma (Mueser et al, 2004).

Everywhere it's been used there is a clear racial prejudice and inequity in practical application. For example, African Americans and Hispanics are over-represented as subjects of IOC orders in New York. African American clients are nearly three times as likely and Hispanics twice as likely as Anglos, to be the subject of court-ordered treatment, based on data reported in 2005 and 2009 (NY Lawyers for the Public Interest). Implementing IOC in Ohio would invite a comparably discriminatory application of court-ordered treatment. Outpatient commitments would take place exclusively in probate court, closed proceedings with no oversight and little ability to track impact. The New York Civil Liberties Union has denounced what they see as racial and socioeconomic biases in the issuing of outpatient commitment orders.

It is not a matter for court dalliance in alleged medical matters of treatment. The law should protect the liberty interests of citizens. **Involuntary Outpatient Commitment (IOC) violates the fundamental rights** of autonomously choosing one's own path including treatment path, of a broad group of people who are not currently a danger to themselves or others. They have not been found incompetent to make their own medical decisions by forcing court-ordered medical treatment. IOC singles out people with psychiatric conditions for this loss of rights. Clearly, our society greatly values individual freedom. Individuals have the right to make lawful decisions about all aspects of their life without undue intrusion from the state or others. The courts have emphasized the principle that every human being of adult years and sound mind has a right to determine what shall be done with his own body. The legal doctrine of informed consent essentially elaborates the principle that, with certain rare and extreme exceptions, nothing can be done to one's body without explicit agreement after a careful review of the risks, benefits, and alternatives, including the alternative of doing nothing. Informed consent must be voluntary, knowing, and competent. Competence to make decisions must be assumed absent a judicial process that removes that right.

It's absurdly broad sweeping. If someone is an imminent danger to self or others then perhaps they should be confined to protect them or the public. If they are not an imminent danger then they should not have their liberty restricted and their freedom to choose or refuse denied. The American Psychiatric Association readily admits that psychiatry has found it impossible to predict violence or dangerousness. Studies have shown that preventive detention does not work, is costly and damages relationships that might help later. Self harm should never be included because it's absolutely undefined. Some people cut themselves as a coping mechanism for past trauma. Others indulge in self-mutilation of tattooing or piercing. Still others indulge in dangerous behaviors for an adrenaline rush such as skydiving. Others may ignore their doctors warnings about diabetes or obesity and go through the McDonalds drive-through.

“Treatment” almost always includes harmful drugs. Many studies now demonstrate the dangerousness of psychiatric medications as well as their potential in causing others to act in ways that are harmful to self or others. The 16-state study conducted by the National Association of State Mental Health Program Directors (NASMHPD)(2006), the one most often cited, drew direct causal links between the prescription of atypical neuroleptic medications, dramatically shortened lifespans and a host of other medical problems, such as those listed below. Similar studies regarding SSRI’s and anti-epileptic/mood disorder medications produced similar outcomes:

- public mental health system clients experience higher rates of medical disease: those prescribed atypicals are 5x more likely than the general public to die of heart attacks; those prescribed SSRI’s are approximately twice as likely to die of heart attacks.
- those prescribed atypicals are 7x more likely to develop diabetes II; those prescribed SSRI’s are twice as likely; those prescribed anti-epileptics 2-3x as likely.
- These individuals lose an average 25 years of life expectancy, with persons considered to have serious mental illnesses suffering an annual death rate of 3.5%, as compared to a death rate for the general population of 1%. Specifically: of those prescribed atypicals, 20-33% will be dead within 10 years; of those prescribed SSRI’s, 20% will be dead within 10 years; of those prescribed lithium, 15% will be dead within 5-10 years.

(The information above, particularly as re. SSRI’s and anti-epileptics, is largely derived from Dr. Grace Jackson’s powerpoint presentation, “Brain Repair,” and accompanying references, presented at the annual ISEPP conference, November 2, 2012, <http://isepp.wordpress.com/brain-repair/>.)

It would basically “sentence” people to a “broken system.” Further, given the studies of early mortality, it may constitute basically, an early death sentence. This legislation is predicated upon a belief in failure rather than a positive belief in strengths. The President’s New Freedom Commission on Mental Health found, “. that America’s mental health service delivery system is in shambles. We have found that the system needs dramatic reform because it is incapable of efficiently delivering and financing effective treatments-such as medications, psychotherapies, and other services-that have taken decades to develop. Responsibility for these services is scattered among agencies, programs, and levels of government. There are so many programs operating under such different rules that it is often impossible for families and consumers to find the care that they urgently need. The efforts of countless skilled and caring professionals are frustrated by the system’s fragmentation. As a result, too many Americans suffer needless disability, and millions of dollars are spent unproductively in a dysfunctional service system that cannot deliver the treatments that work so well. A fragmented services system is one of several systemic barriers impeding the delivery of effective mental health care.” (2002)

It is impossible to predict recovery or other positive outcome. I was hospitalized over 20 times. I believe the world would have been not so good a place had people given up on me after three or five times.

“Family” generally perceives the situation as worse than it is. The major proponents of this legislation, NAMI represent family members who are usually unable to be objective regarding someone so close to them.

The underlying issue is the lack of community based care and this legislation won't "fix" that problem. Outpatient commitment laws force people to comply with and accept the inadequate services available in the community. We have proven methods of helping people in the community without the use of force and coercion. Proven non-coercive methods of TIR, EMDR and other proven trauma based approaches are more effective and have more durable results than the talk therapy and/or symptom management approaches including medications. **IOC remains unproven.** No empirical evidence comparing court-ordered community mental health services and supports with comparable programs offered on a voluntary basis show any difference in outcomes. (Policy Research Assoc., 1998; RAND Corp., 2000; Steadman et al, 2001; Swartz et al, 2009). **What works is the continued and increased investment and enhancement of our community-based mental health system** as there are still plenty of people who are being turned away from services they need, want, and request. Supportive housing has been demonstrated to promote stability and engagement. Other services that work include peer support and engagement programs, assertive outreach programs, advance directives, counseling, as well as initial and ongoing training for people in the field, including conservators, court personnel and mental health treatment providers. Some New York physicians, citing a lack of community case managers required by the law (absent in Ohio's SB350), note that the statute replicates all the mistakes of the past by mandating care in the community without providing the necessary resources. "In theory, if a person doesn't comply with the judge's ruling, that patient can be sent to the inpatient ward," said Harvey Bluestone, MD, director of the Dept. of Psychiatry at Bronx-Lebanon Hospital Center in New York. "But in order to make this work, you need a lot of case managers to follow these people around and identify them. It is not clear how to get the patient into the hospital, or how you would hold them even if you did get them here."

Outpatient Commitment is costly. As an example, New York budgets \$32 million annually for its IOC program ("Kendra's Law"). Actual expenditures are considerably higher than that amount. Additionally, only 1.7% of the Office of Mental Health population in NY (NY's equivalent to CT's DMHAS), have been committed via Assisted Outpatient Treatment (AOT – NY's version of Involuntary Outpatient Commitment). Those 1.7% are using 25% of the system's Assertive Community Treatment (ACT) services, thus leaving clients in voluntary services with fewer resources and services (Swartz et al, 2009).

Force and coercion do not work. I taught my kids to ride a bicycle in the usual way. I held the back of the seat and ran alongside for a while and then eventually, I let go. I had to let go so my kids could experience freedom, liberty and growth. I had to let go even though I knew that they would get hurt, that they would at least fall and skin their knee and there was a good possibility that they could crack their skull. If I hadn't let go, it wouldn't have been love and fear of them getting hurt. It would have been abuse because it would have denied them the potential for freedom, liberty and growth. NAMI and our system sometimes mistakes the creation of a safety net for caring but in reality, it's a strait-jacket that stifles our potential.

Problems with forced medication as mental health prevention:

However, often, forced medication orders are not subject to appeal. Once people get these orders, it is almost impossible to stop the forced treatment regardless of recovery status or how stable people are. The problem is that medical care should be done by doctors, not judges. Even Fred Frese from Ohio and from Treatment Advocacy Center and NAMI says there is not nearly enough oversight to these laws.

Even he says there needs to be more consumer input. Being forced to take a treatment you think may harm you is extremely traumatizing. If we want to reduce discrimination and prejudice against people with mental health labels, then we need access to the same civil and criminal protections as other people. Forced medication orders are essentially saying, "You might commit a crime in the future, so we're going to do this to you now so it won't happen." Guilt before innocence, and even guilt before crime. Mandated court "treatment" usually consists of medication compliance however, On the subject of **forced medication** the APA is equivocal, noting that the constitutionality of the practice is uncertain. "If forced medication is permitted, it should be allowed only if a court specifically finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication," because the ordered drugs often have serious or unpleasant side-effects such as tardive dyskinesia, neuroleptic malignant syndrome, excessive weight gain leading to diabetes, addiction, sexual side effects, and increased risk of suicide.

The proposal would limit privacy rights and confidentiality during inpatient commitment by allowing treatment providers to talk to anyone with whom the patient has lived in the previous year as well as parents, siblings or children of the patient. Sometimes people do not have good relationships with family members and possible trauma in those relationships causes them to not want to include those family members in their treatment planning. Applying a framework of the criminal justice system, where police are allowed to talk to neighbors, families and landlords when investigating a crime, is different from asking questions about a person with mental illness. Mental illness is not a crime, therefore different standards should apply.

SB350 is poorly crafted. For example, there are places where it refers to "probable cause" and other places where a "clear and convincing" standard is used.

NAMI Connecticut testified as follows:

We know that people who need medications go without them for a variety of reasons including serious adverse side effects, stigma, denial, conditions of the illness leading to a lack of insight, and lack of access to services including access to medications and other community based treatments. Although written with good intentions, this proposal will not help improve treatment for persons with psychiatric conditions, also for a variety of reasons:

- Coerced treatment greatly damages future treatment relationships
- Relationships built on trust, not force, lead people to make good decisions regarding their health
- Denial and disapproval regarding the illness and medications is very common and usually a temporary stage of the illness and recovery process

Most people testifying today will have once been in that stage and moved past it without an involuntary outpatient commitment.

- A lot, if not most, of what works in mental health depends on relationships, particularly the relationships between the people dealing with mental health issues and their partners in recovery such as providers, family members and other social supports chosen by the individual. Forced treatment, including and in particular, forced medication administration, will make it less likely, now and in the future, that individuals will trust the people and systems around them to support and help them with their mental health conditions.

This trust includes having conversations with people affected by mental illness and listening to their stories, their preferences i.e., what medications would have the least side effects and are effective for that individual, and their goals and dreams.

- 4. Given that Ohio already has legislation in place for Court-Ordered Outpatient Commitment, what is your position regarding the existing law? Do you believe that SB 350 is needed? Why or why not? Do you have current direct experience with the current Court-Ordered Outpatient Commitment Law in your community or across Ohio? If yes, do you believe that the current Law is used effectively? Why or why not? If possible, site examples.**

I am opposed to the existing law. It represents oppression of people and it makes several false assumptions without backing in fact. I do not believe SB350 is needed because it would further confuse matters and create a system that is more oppressive and the changes espoused in SB350 are based in even more false assumptions. I do not have lived experience in Ohio but I have talked of this with many who have. The current law is not used consistently and rather than try to force it into use, I think we should consider decreasing or limiting its use further.

- 5. If you oppose SB 350, are there any changes that would cause you to reconsider your current position? Please specify.**

I am opposed to SB350. Short of abolishing the existing laws for civil commitment, I would recommend making such laws more difficult to implement because depriving people of their liberty should not be easy and must be taken with due seriousness. One way to accomplish this would be to raise the legal standard from SB350's "probable cause," and to raise it from the existing "clear and convincing" to "beyond a reasonable doubt." ("clear and convincing" used 15 times, "probable cause" used 7 times, "hospitalization" to "court order" 63 times, medication 33 times, commitment 93 times) I have attached an outline for a model law suggested by the Bazelon Center for Mental Health Law.

- 6. If you currently support SB 350, are there any changes that would cause you to reconsider your position? Please specify.**

I do not support SB350.

Do you have other recommendations that would strengthen or add further clarification to the proposed legislation? Please specify.

I am opposed to any recommendations that would strengthen the proposed legislation. I am opposed to any legislation that makes it easier to deprive people of their right to liberty. I have attached an outline for a model law suggested by the Bazelon Center for Mental Health Law.

- 7. Please discuss any positive or negative ramifications you think SB 350 will have for the following:**
- a. People with severe and persistent mental illness (SPMI) living in the community and/or being discharged from psychiatric hospitals to the community;**

Outpatient Civil Commitment or euphemistically named "Assisted Outpatient Treatment" is essentially using the force and coercion of the judiciary. Too many of my peers are survivors of abuse, neglect and trauma. In many studies over 90% of people of all psychiatric disorder diagnoses are survivors of abuse, neglect and trauma. This bill would do nothing to address the issues of abuse, neglect and trauma and instead would further traumatize people through the use of force and coercion. An unproven system intervention that results in early death would be better replaced by (for example) providing people with service animals. At least that has data and research to back its feasibility. A better approach would be to acknowledge the key impact of addressing the social determinants of health (housing & economic stability and social connection and support). Using peer run approaches and a strengths based approach that is trauma informed would build a more successful system that is inviting and welcoming of those with emotional distress.

b. Family members of people with SPMI;

People with psychiatric issues who receive public mental health services are dying at a national average age of 52 and it is falling while the average age of death overall in the country is 78 and rising. Many of the problems are related to the use of psychiatric medications and it is not family members who are taking those medications. It is not family members whose lives are shortened by over 25 years. It is not family members whose liberty rights are threatened or compromised. Family members should not have any rights over other adults. SB350 would create a way to make it easier to force another family member to take drugs, to have their life shortened, to be forcibly made to somehow become less of a pain in the ass to their family.

c. Providers of services and supports for people with SPMI;

There are many reasons why the system is overly burdened and being able to force more into treatment isn't a valid reason. The system can't cope with current demand and to force some few into treatment may mean that others would be forced out of care to make room for the few. Those forced out may suffer relapses and loss of hope until they too become the ones to be forced. It just doesn't make sense.

d. Probate Judges and Courts;

If I were a judge, I would find this legislation offensive. It assumes that the existing tool is there and not being used by some judges because they are ignorant of the law. I would never make that assumption. I believe the courts understand and weigh peoples' liberty interests and if they choose not to make use of existing law, it is not our place to try and force them to use it.

e. Law Enforcement Officers;

I suspect that law enforcement officers would not want to waste time picking people up for non-compliance with treatment when they are not an imminent danger to themselves or others.

f. Other

8. Is there any additional information that you would like to share with us regarding your position on SB 350?

I am offended at the way this legislation, backed by NAMI indulges in worst-case scenario, fear-mongering. By taking a single or very few rare instances and attempting to create public policy based on those few isolated and rare instances is discrimination at its worst. It places blame on an entire population of innocent people and may be grounds for constitutional challenge.

Pat Risser-Representing consumer opposition

Moderator: What language in SB 350 causes you to believe forced medication would be part of court ordered treatment?

Pat Risser: In every study done on involuntary outpatient treatment across the country the primary treatment is compliance with medication...I mean every study back then.

Moderator: Do you think providing outpatient care for individuals with mental illness will help reduce the effects of stigma you have outlined in your testimony (requests clarification) I don't know if this means mandates or any outpatient treatment?

Question writer: any outpatient treatment

Moderator: OK, do you believe providing any outpatient care for individuals with mental illness could help reduce the effects of stigma you outlined in your proposal.

Pat Risser: If people voluntarily seek treatment...I'm not sure I understand the question...

Moderator: Second question, do you feel all judges are well informed with issues those with mental illness face when they refer care for those with mental illness?

Pat Risser: No I don't feel judges are well informed about what gets labeled as mental illness. I don't think judges are very informed about cancer or heart disease but they don't need to be, they need to know the law. The rule of judges is to protect our liberty interests not to intervene in treatment.

Moderator: How do you respond to someone who says "outpatient commitment saved my life"?

Pat Risser: I don't know how to respond to that because I don't know what alternatives were available. That statement is reflecting a belief not a fact. Had voluntary services been available and that person chosen those services they might now be claiming the voluntary services saved their life. Like I said it's a belief not a fact, I hope the information I have presented has been backed by studies and research.

Moderator: With our prison system at any given time housing up to 30 percent of people that are mentally ill and 60 percent of those that are mentally ill do not believe they are mentally ill. There are potentially people that may harm themselves or others. How do you see the court handling these people?

Pat Risser: Well I have not seen these studies that back the figures you've cited. I have not seen those so... and I have done extensive research so I do not know where those numbers are coming from so I can't speak to the numbers. The fact that there may be somebody with a diagnosis of mental illness in the jail or prison system merely says to me that they have somehow been adjudicated and sentenced based on the commission of a crime, not anything related to an alleged mental illness. I know that people can and do, get picked up and arrested and serve time for all sorts of issues. Nationally I have testified, I think the best jail diversion program is for the officer on the street to turn his head instead of

picking people up for a minor infraction. Urinating on a bush, I don't think that warrants some of the punishment they receive or labels they receive. Good help is not available to the people in the communities, good help is not necessarily available to people in jail or prisons, forcing people into those systems does not mean good help is going to be created. I think this legislation if we want to create legislation that is going to have an impact, we need to be aiming and creating better systems rather than funneling people into systems that are broken.

Moderator: OK we are out of time

****End of Testimony****