

County of Summit

ADM
BOARD



**Alcohol, Drug Addiction &
Mental Health Services Board**

Summit County Ohio and Assisted Outpatient Treatment

*Doug Smith, M.D.
Medical Director/CCO*

Recovery Starts Here

www.admboard.org





ORC 340 Mandate

- Assess community mental health prevention and education, treatment and support needs.
- In collaboration with other community stakeholders, the ADM Board plans for and funds services, and evaluates their impact.
- This is done through contracts with over twenty-five agencies. The ADM Board does not provide any direct services.





How were we created?



- Kennedy CMHCA of 1963
- 1967, Ohio enacted Amended Substitute House Bill (ASHB) 648, creating Community MH & MR Boards, AKA “648 Boards.”
- 1980, passage of ASSB 160 transferred responsibilities for MR to DD Boards & 648 Boards became Community MH Boards.
- 1988; MH Act signed by Governor Richard Celeste gradually shifted inpatient funds to local Boards to provide mental health and services essential for community living, including housing, case management and transportation. Full shift by 7/1/99.
- 1989- The Ohio Alcohol and Drug Addiction Services Act established the added the responsibility for AoD prevention and treatment services to local Boards.





More recently...

- 1995 Olmstead Decision & ADA- Title II
 - Integration
 - requires that public entities make 'reasonable accommodations'
 - to avoid discrimination on the basis of disability
- 2013- ODMH and ODADAS merger- Ohio MHAS
- 50 ADAMH Boards
 - Each with a 14 member Board of Directors

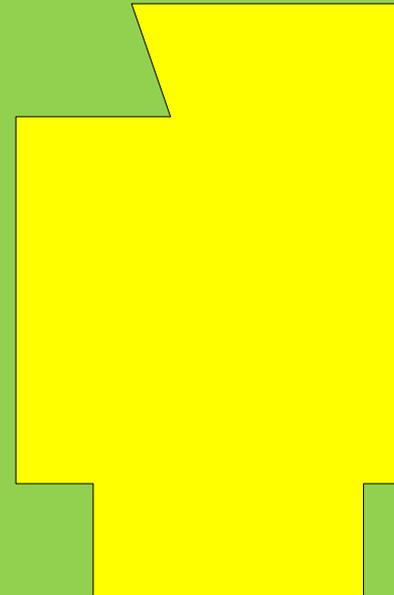




Summit County

2014 Estimates:

- 542,000 population
(4th largest in Ohio)
- 14.8% Black
- 1.9% Latino
- 2.8% Asian
- Median household
income \$49,669

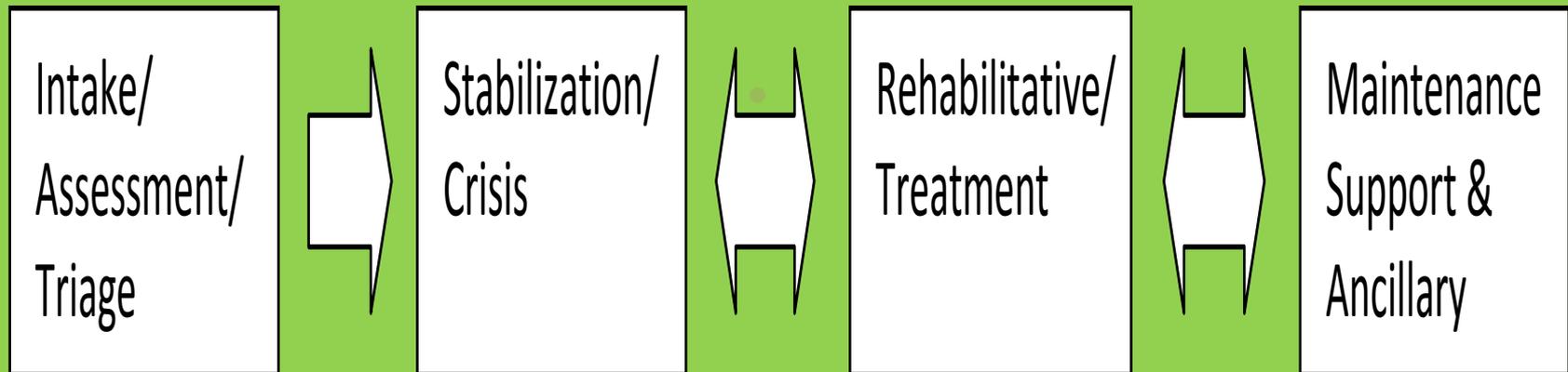


Summit County ADM Board

- A network of 25* local affiliated agencies
- About 50,000 Summit County residents are touched by ADM funded services yearly.
- Services across the lifespan beginning with unborn children of depressed mothers, to birth to older adults

Continuum of Care:

An integrated system of care that guides patients over time through a array of health services and levels of care. A typical continuum of care spans the following categories:



Due to the chronic nature of many mental illnesses and addictions, a client may go back and forth between levels of care.

Summit County ADM Board Funding

- 80% of ADM Budget comes from Tax Levy Dollars
 - 10% Federal
 - 10 % State
- ~ \$40 million dispersed to many agencies/programs
 - 65% MH and 35% AOD
- Only 6% of funds are used for Board administrative services and overhead.

Role of the ADM Board

In addition to funding services:

- Needs assessments
- Coordinate Services/Promote Collaboration
- Promote Evidence-Based Practices
- Grant writing
- Client Rights
- Community Advocacy
- Population Advocacy
- Workforce Development
- Collaborate with others to help achieve the Triple Aim:
 - Reduce cost of care
 - Improve the patient experience
 - Boost the overall health of citizens of Summit County

“Experience should teach us to be most on our guard to protect liberty when the government’s purposes are beneficent ... The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well meaning, but without understanding.”

Justice Louis Brandeis

Olmstead v. United States, 277 U.S. 438 (1928)

“A person who is suffering from a debilitating mental illness, and in need of treatment is neither wholly at liberty nor free of stigma.”

Chief Justice Warren Burger

Addington v. Texas, 441 U.S. 418(1979)

Why Outpatient Commitment/Assisted Outpatient Treatment? The revolving door patient

There is a group of patients who have repeatedly gone through the following cycle:

- Presents with an acute psychosis
 - Schizophrenia, schizoaffective or bipolar
- When symptomatic, becomes dangerous to self or others (or gravely disabled)
- Responds to pharmacologic treatment in the hospital but
- Fails to appreciate the benefits of ongoing treatment
- Discontinues treatment in the community
- Decompensates and begins the cycle again

Why outpatient commitment?

The dangers of the revolving door

- Psychosis is generally a painful/terrible experience.
- Repeated episodes of psychosis may result in a deteriorating course of illness.
- Untreated, psychotic mentally ill persons are at higher risk of committing violent acts than stable mentally ill persons or the general population.
- Long-term institutionalization is not necessary for the great majority of these patients.



"We're encouraging people to become involved in their own rescue."

"We're encouraging people to become involved in their own rescue."

Ohio Civil Commitment Criteria

- Individual must have a "Mental illness" and 1 or more of following:
 - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
- (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
- (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
- (4) Would benefit from treatment 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;

In Re Burton: 1984 Ohio Supreme Court Decision
Burton was IST-U on a homicide charge

- “Totality of the circumstances test” which allows consideration of prior dangerous propensities. Consideration should include:
 - Whether the individual represents a substantial risk of physical harm to self or others
 - Present mental and physical condition of the individual
 - Whether the person has insight into his condition so that he will continue treatment as prescribed or seek professional assistance
 - Any past history which is relevant to establish the person’s conformity to laws, rules, etc.
 - If in remission, the probability that the person will continue treatment to maintain the remission

OPC in Summit County

Working assumptions

- Criteria for commitment same for hospitalized patients as for those committed to the Board in the community
- Commitment does not allow for forcible administration of medication
- Noncompliance with treatment (including medication) alone does not allow a patient to be involuntarily returned to hospital
- The threshold for a court ordered evaluation is lowered
 - At the earliest signs or symptoms of decompensation consistent with a well established pattern, the treating psychiatrist can ask that the probate court issue an order for a “forced evaluation” to the emergency service to determine the need for re-hospitalization.

OPC in Summit County

(10) Clinical Guidelines (Geller, H & CP, 1990)

- Patient must want to live in the community
- Patient must have previously failed in the community
- Patient must have competency to understand the stipulations of OPC
- Patient must have the capacity to comply with the community treatment plan
- The treatment(s) have been demonstrated to be effective with the patient

OPC in Summit County

Clinical Guidelines (Geller, H & CP, 1990)

- The ordered treatment(s) must be such that they can be delivered by the community system, are sufficient for the patient's needs, and are necessary to sustain community tenure.
- The ordered treatment can be monitored by the community treatment system.
- The community treatment system must be willing to deliver the ordered treatment and to participate in enforcing compliance with these treatments.
- The public-sector inpatient system must support the OPC program.
- The outpatient must not be dangerous when complying with the ordered treatment.

OPC Process in SC

- Individual civilly committed to the SC Board and treated in a locked psychiatric unit or state hospital “up to 90 days.”
 - Average LOS is less than 2 weeks.
 - Outpatient commitment used as a less restrictive alternative to continued involuntary hospitalization for individuals who meet the clinical criteria.
- Upon discharge the individual automatically remains on Assisted Outpatient Treatment for the remainder of the 90 days.
- Virtually all patients on OPC are treated by one agency (Community Support Services -CSS).

OPC Process in SC

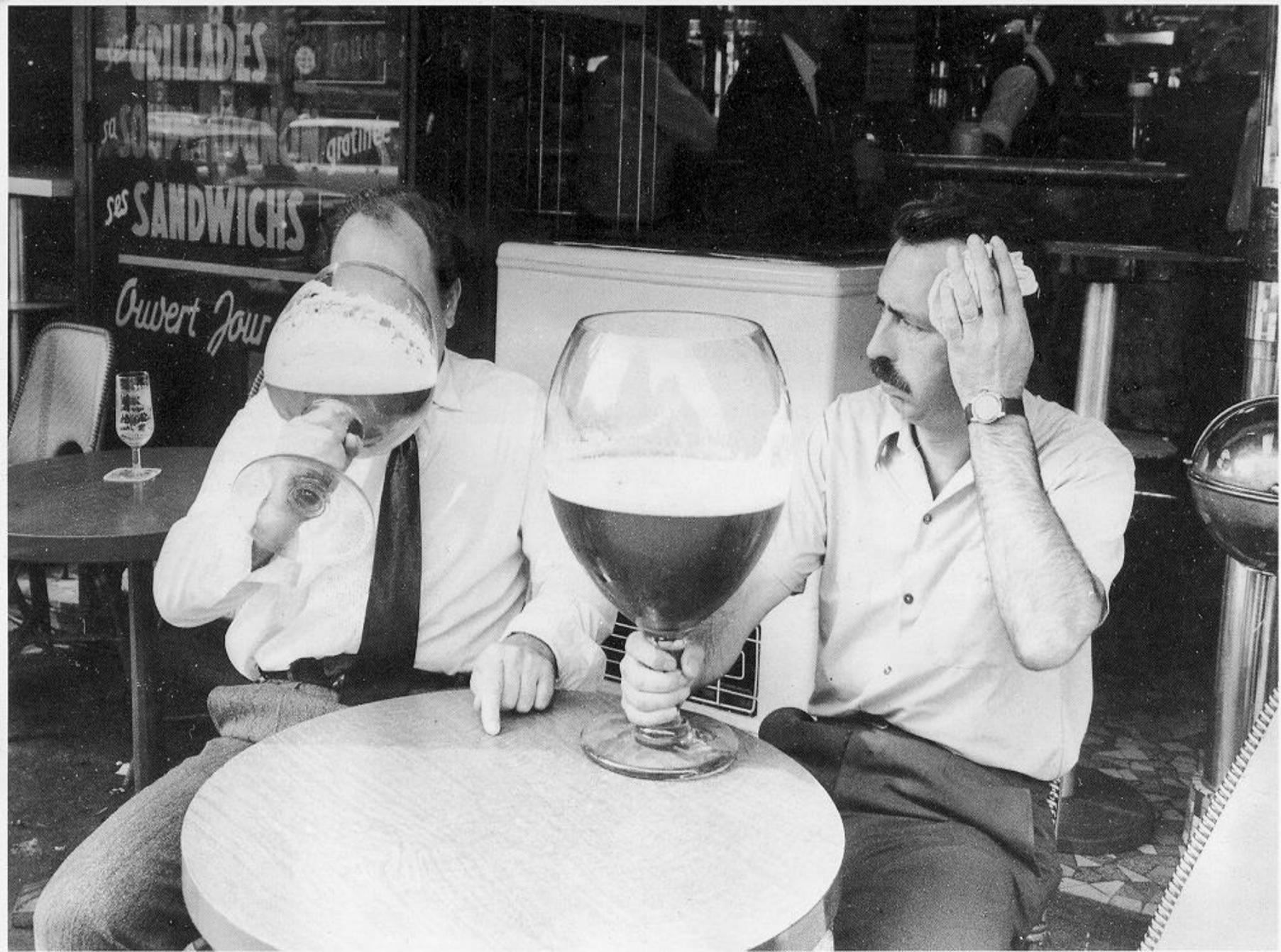
- Ongoing coordination between CSS, ADM Board, and Probate Court regarding legal dates, monitoring timelines, and clinical value.
- Case manager for patient completes monthly update, reviewed by supervisors at CSS and then by SC ADM Board Chief Clinical Officer.
- Determination made regarding discontinuing OPC, continuing OPC, or returning to court for renewal after 90 days.
- Court hearings with patient having an attorney and ADM Board attorney representing the community.
- Quarterly meeting with hospitals, probate court, psychiatric emergency services, and ADM Board to discuss process.

SC OPC Monitoring Form

- **Reminds team of Ten Clinical Guidelines for the use of Involuntary Outpatient treatment:**
 - **1. The patient must express an interest in living in the community.**
 - **2. The patient must have previously failed in the community.**
 - **3. The patient must have that degree of competency necessary to understand the stipulations of his or her involuntary community treatment.**
 - **4. The patient must have the capacity to comply with the involuntary community treatment plan.**
 - **5. The treatment or treatments being ordered need to have demonstrated efficacy when used properly by the patient in question.**
 - **6. The ordered treatment or treatments must be such that they can be delivered by the outpatient system, are sufficient for the patient's needs, and are necessary to sustain community tenure.**
 - **7. The ordered treatment must be such that it can be monitored by outpatient treatment agencies.**
 - **8. The outpatient treatment system must be willing to deliver the ordered treatments to the patient and must be willing to participate in enforcing compliance with those treatments.**
 - **9. The public sector inpatient system must support the outpatient system's participation in the provision of involuntary community treatment.**
 - **10. The outpatient must not be dangerous when complying with the ordered treatment.**

SC OPC Monitoring Form

- In case/care manager's opinion, does this patient meet all ten (10) clinical guidelines for outpatient commitment?
- Considering the range of circumstances that influence this client's ability to respond to treatment, has he/she sufficiently complied with treatment recommendations?
- Is the client able to be safely discharged from involuntary commitment?
- Is there a reason to consider returning this client to an inpatient commitment status? Explain:
- Are there changes in service recommendations that would enhance his/her ability to effectuate discharge from involuntary treatment? Explain:
- Document changes in the treatment plan since the last reporting period:
- If commitment is in final month, do you intend to ask Probate Court to extend commitment?
- If not planning to ask for an extension of commitment, what is the rationale? Explain:
- Comments from CSS Medical Director:



Effectiveness of OPC in Summit County

Psychiatric Services, 47:1251-1253,1996

- The effects of OPC were studied in 20 patients committed to the board.
 - Mirror image comparison of the 12 months before and during commitment
- Compared to the period 12 months before the commitment order, study subjects:
 - Had markedly fewer hospital admissions
 - Had markedly fewer hospital days
 - Kept more appointments with their psychiatrist
 - Had fewer visits to psychiatric emergency services

Table 1: COMPARISONS 12 MONTHS
BEFORE AND
12 MONTHS DURING OUTPATIENT
COMMITMENT

	Before Outpatient Commitment	During Outpatient Commitment	Statistical Significance
State Hospital:			
Admissions (mean)	1.5	0.4	t=6.84, df=19, p<.0001, 2-tail
Bed Days (mean)	133.0	44.3	t=2.77, df=19, p<.01, 2-tail
General Hospital/CSU:			
Admissions (mean)	0.3	0.5	NS
Bed Days (mean)	7.5	6.2	NS
Psychiatric Emergency Services (PES) Presentations (mean)	2.4	0.7	t=2.56,df=19, p<.02, 2-tail
Psychiatric Appointments (mean)	5.7	13.0	t= 2.30, df=19, p<.03, 2-tail
Day treatment Sessions (mean)	22.5	59.5	NS
Case Management Contacts (mean)	64.2	82.5	NS
Number of Patients Living Independently	9 (45%)	10 (50%)	NS
Number of Unemployed Patients	17 (85%)	17 (85%)	NS
Number of Patients with Arrests/Convictions	5 (25%)	1 (5%)	NS
Number of Patients Abusing Drug/Alcohol	7 (35%)	6 (30%)	NS

Outcome after OPC termination

- 18 of 20 terminated after a mean of 20.6 months
 - 10 terminated by treating psychiatrist
 - 5 terminated by the court
 - 3 administratively terminated
- Outcomes mixed
 - 10 had a good outcome
 - 8 had a poor outcome
 - All 3 administrative terminations had a poor outcome
 - Relapse occurred at a mean of 9.1 months after termination
 - Range of time to relapse 1 to 20 months

Observations about OPC in Summit County

- Program has been in place since 1992
- There has never been dedicated funding for OPC in Summit County
- Almost all patients are treated at one agency (CSS)
 - ACT or intensive case management depending on individual circumstances

Observations about OPC in Summit County

- At its inception, it was widely scrutinized
 - Disability Rights Ohio, ODMHAS, OACBHA
 - Not liked by some advocates but apparently “legal”
- Strong support within court, board and most of the clinical community
- Now seen as a model in the state
 - But only a few counties have implemented OPC

Observations about OPC in Summit County

- Tension between court and clinicians about maintaining OPC over time
- “Teeth” are weak
- Treatment over objection only occurs in the hospital
 - But treatment orders carry-over into the community setting
- Clinicians cannot imagine not having this tool available
- About 60 patients on average on OPC at a given time, out of 50K (.12%) touched by the greater care system, out of total county population of 542K (.011%). Very selective using solid criteria.

Problems with OPC in Ohio

- Dangerousness based
 - Adds to stigma of mental illness
 - Appears to place dangerous, mentally ill people in the community
- A committed patient is assumed to have decision-making capacity
 - Committed patients retain the right to refuse treatment
 - No court process for treatment over objection (forced medication)
- It is unclear what the court is actually ordering when a patient is committed to an outpatient setting
 - It appears to allow “coercive monitoring”

Problems with OPC in Ohio

(continued)

- Difficult to maintain over time
 - Harder to argue dangerousness the longer someone is stable ***because*** of the court mandated treatment
- Not based on lack of insight or anosognosia, which impairs decision-making capacity, and yet that is what leads to the revolving door phenomenon

Updated OPC Law

- SB43 effective 9/17/14
- Crafted with input from “everyone” - NAMI, OACBHA, TAC, Attorney General, OPPA, OPA, DRO, etc.
- Goal of increasing number of counties making use of OPC.
- Goal of allowing individuals to be placed on OPC while an outpatient – without having to be first civilly committed to a hospital.
 - More preventive and removes some of the “problems” with OPC prior to the updated law.
 - Added 5th criterion
-

New OPC 5th Criterion

- (a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:
 - (i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.
 - (ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:
 - (I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.
 - (II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.
 - (iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.
 - (iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.
- (b) An individual who meets only the criteria described in division (B)(5)(a) of this section is not subject to hospitalization.

New OPC 5th Criterion

- NAMI and others very interested in this option
- 3 occasions so far in Summit County
 - Families waited until their loved one had decompensated.
 - All were assessed as per process and found to clinically require hospitalization.

Future Plans

- Establish criteria for periodic mental status hearings in Probate Court
 - All, within 2 weeks after discharge from hospital
 - Others based on need for stronger “black robe effect”
 - Range of weekly to monthly, depending on need
 - Case Managers will transport patients to the hearings
 - Different day of the week than inpatient civil commitment hearings





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Alcoholism, drug addiction and mental illness are real medical conditions that can affect anyone.

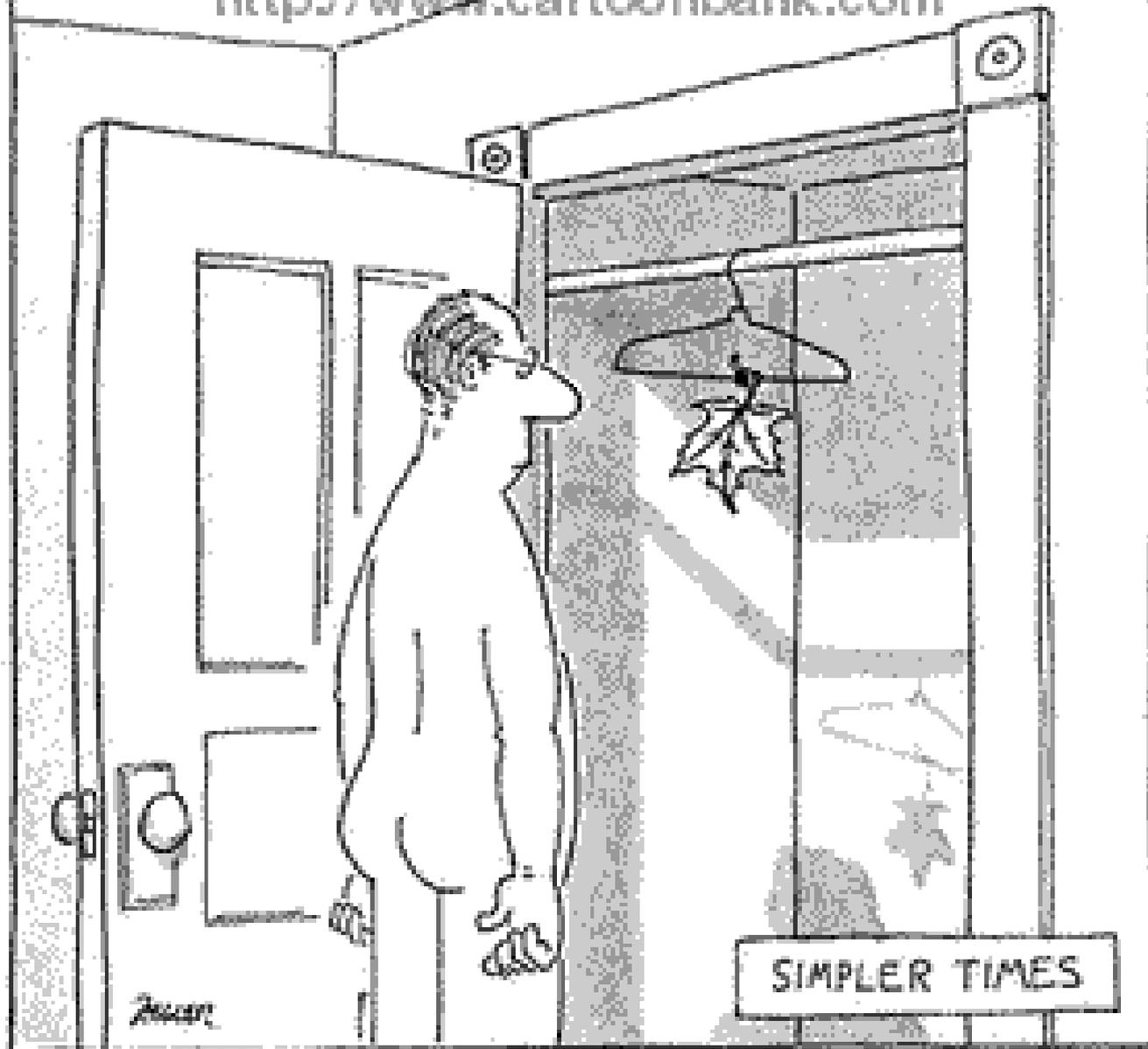
Recovery is possible with the right services and supports.

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SIMPLER TIMES

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Mental Health Services Board**

Doug Smith, M.D. , DFAPA

www.admboard.org

330.564.4083

DougSmith@admboard.org

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