To Stay at Home: Analysis of Rights and Recommendations on Procedures for Persons Receiving Mental Health Services in the Community

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TO STAY AT HOME: ANALYSIS OF RIGHTS AND RECOMMENDATIONS ON PROCEDURES FOR PERSONS RECEIVING MENTAL HEALTH SERVICES IN THE COMMUNITY

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I. INTRODUCTION .......................................................... 221

II. INFORMED CONSENT AND THE RIGHT TO REFUSE TREATMENT—

   A BRIEF OVERVIEW .................................................. 222
   A. General Principles on Informed Consent ....................... 222
   B. Exceptions to the General Requirement for Informed Consent
      1. Emergencies ................................................. 224
      2. Involuntary Confinement ................................. 225
      3. Guardianship ............................................. 227

III. OHIO PROCEDURES FOR ACCESS TO TREATMENT ............... 228
   A. Voluntary Treatment ....................................... 228
      1. Procedures for Voluntary Admission ................... 228
      2. Rights of Competent Persons Receiving Voluntary Treatment ....................... 228
   B. Involuntary Commitment .................................... 229
      1. Emergency Admission ................................... 229

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2. Initiating Commitment through Probate Court ........................................... 230
3. Probate Court Commitment Orders ......................................................... 231
4. Post-Commitment Procedures ............................................................... 231
   a. General ......................................................................................... 231
   b. Trial Visits from Hospital ......................................................... 232
   c. Transfers within the Community .................................................. 233
   d. Transfers from Community to Hospital ....................................... 234
5. Rights of Persons Subject to Involuntary Commitment .............................. 235
   a. General Rights ............................................................................ 235
   b. Informed Consent Requirements for Persons Involuntarily Committed under State Law .................................................. 236
   c. Ohio Department of Mental Health ("ODMH") Policy on Informed Consent .............................................. 236
6. Probate Court Authority ........................................................................ 237
   a. Medication Decisions ................................................................... 237
   b. Contempt Powers of Probate Court .............................................. 238
C. Guardianship .......................................................................................... 238
   1. Summary of Procedure .................................................................. 238
   2. Scope of Guardian's Authority ...................................................... 239
      a. General ....................................................................................... 239
D. Advance Psychiatric Directives ................................................................ 239
E. Criminal Justice System .......................................................................... 240
   1. Probation ....................................................................................... 240
   2. Parole ............................................................................................ 241
F. Other Applicable Statutes and Regulations .............................................. 241
   1. Fair Housing Amendments Act ................................................... 241
   2. Mental Health Housing Assistance Program .................................. 242
   3. Medicaid ....................................................................................... 242
   4. Ohio Department of Health Regulations ...................................... 243
IV. STRATEGIES FOR INTERVENTION ......................................................... 243
   A. Introduction ................................................................................... 243
   B. Development of ADAMH Board Policy ......................................... 244
   C. Guardianship ................................................................................... 244
      1. Discussion .................................................................................. 244
      2. ADAMH Board/Agency Strategy .............................................. 244
   D. Community Placement and Civil Commitment ................................ 245
      1. Discussion .................................................................................. 245
2. Transfer to more structured setting in the community ........................................... 245
3. Threat of transfer to an in-patient facility .......................................................... 246
4. Treatment orders .................................................................................................. 246
5. Contempt ............................................................................................................... 247

E. Trial Visits from an In-patient facilities ............................................................... 247
   1. Discussion ........................................................................................................... 247
   2. ADAMH Board/Agency Strategy .......................................................... 247

F. Advance Psychiatric Directives ........................................................................ 247
   1. Discussion ........................................................................................................... 247
   2. ADAMH Board Strategy ........................................................................... 248

G. Criminal ............................................................................................................... 248
   1. Discussion ........................................................................................................... 248
   2. ADAMH Board Strategy ........................................................................... 249

H. Treatment as a Condition for Services ............................................................... 249

I. Persuasion ............................................................................................................. 250
   1. Discussion ........................................................................................................... 250
   2. Therapist strategies .......................................................................................... 250
   3. ADAMH Board/Agency Strategies .......................................................... 250

V. CONCLUSION ..................................................................................................... 251

I. INTRODUCTION

The gains in shifting the focus of treatment of persons with mental illness from the hospital to the community are being threatened because persons discharged from an in-patient setting often do not follow through on treatment recommendations and, as a result, their conditions deteriorate. The deterioration causes behaviors which often lead to re-hospitalization and serious repercussions in the community. In some areas the community is pressing to re-institutionalize people more frequently and for longer periods.

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3 There has been a dramatic decrease in Ohio in the number of persons with mental illness who are treated in state psychiatric hospitals. In 1983, the average daily resident population was 4,316; in 1992, the figure was down to 2,402. STUDY COMMITTEE ON MENTAL HEALTH SERVICES, THE RESULTS OF REFORM: ASSESSING IMPLEMENTATION OF THE MENTAL HEALTH ACT OF 1988 80 (1993).

4 Failure to participate in outpatient care also results from a shortage of necessary services in the community, or lack of continuity of care from the hospital into the community. Ohio has found, as have other states, that as patient population in institutions has decreased, the dollars from the institutions has not followed the patients to the community. Clermont County ADAMH Board v. Hogan, No. 93 CV-0003 (Clermont Cty. filed Jan. 4, 1993) was filed to force the Ohio Department of Mental Health to provide adequate funds to the counties for community services.
Before the pendulum swings back to the use of institutions as the primary treatment modality for persons with severe mental illness, there should be a re-examination of the alternatives available to community care providers to ensure compliance with treatment outside of the hospital. This article will focus on the alternatives available in the Ohio mental health system, which is fundamentally oriented towards community-based treatment, and the effects of this orientation.

II. INFORMED CONSENT AND THE RIGHT TO REFUSE TREATMENT—A BRIEF OVERVIEW

A. General Principles On Informed Consent

Treatment, including psychotropic medication, cannot ordinarily be given to a legally competent individual without that individual’s informed consent. Persons are presumed competent unless found otherwise by a probate court, and are guaranteed all civil and statutory rights. An essential civil (and human) right is embodied in the proposition that "every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body."

Informed consent for treatment is mandated when a legally competent individual who suffers from a severe mental illness refuses life-saving medical intervention for apparently delusional reasons. In In re Milton the plaintiff, a patient voluntarily admitted to a state psychiatric hospital, refused treatment for a malignant tumor because it was against her belief in faith healing. The

5 This introductory material is provided as a general framework for the discussion and recommendations which follow, rather than as a comprehensive analysis of principles of informed consent and the right to refuse treatment.


8 Ohio, like most states, embodies this principle in statute. OHIO REVISED CODE ANN. § 5122.301 (Baldwin 1993).


10 505 N.E.2d 255 (Ohio 1987).
state argued that plaintiff was unable to give informed consent because her belief system was based on a delusion that she was the wife of a well known evangelist and faith healer. The Ohio Supreme Court held that an adult who has not been adjudicated incompetent may not be compelled to submit to treatment that others deem to be in the person’s best interest, despite the importance of the treatment in extending the person’s life. Had the patient been involuntarily committed, the result would not differ since "commitment would not be tantamount to a finding of incompetency."  

The value placed on informed consent for non-invasive psychiatric care was affirmed by the United States Supreme Court in Zinennon v. Burch. Darrell Burch was found wandering along a highway and appeared disoriented and injured. He was brought to a nearby private psychiatric facility where he was allowed to sign voluntary admission papers and consent to treatment forms. At the time of admission to the private center, Burch was described as hallucinating, confused, psychotic and as believing he was "in heaven". Three days later he was transferred to Florida State Hospital (FSH), a state psychiatric hospital, where he once again signed voluntary admission and treatment forms. The staff physician at FSH noted that Burch was "disoriented, semi-mute, confused and bizarre in appearance and thought", "extremely psychotic" and appeared to be "paranoid and hallucinating." 

Upon discharge five months later, Burch filed suit alleging that the hospitals had obtained consent to admission and treatment despite clear evidence that he was incapable of giving informed consent. The state’s failure to invoke involuntary commitment proceedings was a deprivation of liberty without due process. The Court observed that, "Burch’s confinement at FSH for five months without a hearing or any other procedure to determine either that he had validly consented to admission, or that he met the statutory standard for involuntary placement, clearly infringes on his liberty interests." 

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11Id. at 257-58.  
12Id. at 257. In Zinemon v. Burch, 494 U.S. 113, 138 (1990) the United States Supreme Court held that an individual who was admitted and treated as a voluntary patient in a psychiatric hospital had a claim under § 1983 because the employees of the hospital did not take adequate steps to determine whether the patient was competent to sign the voluntary admission form.  
14In Florida, a hospital may admit an individual voluntarily if the individual has made an application "by express and informed consent". FLA. STAT. ch. 394.459(3) (a) (1981). "Express and informed consent" is defined as "consent voluntarily given in writing after sufficient explanation and disclosure... to enable the person... to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion." ch. 394.455(19).  
15Zinemon, 494 U.S. at 118.  
16Id. at 119-20.  
17Id. at 131. The Court recognized that "[t]he characteristics of mental illness...create special problems regarding informed consent. Even if the State usually might be justified
B. Exceptions to the General Requirement for Informed Consent

1. Emergencies

Courts have almost universally recognized an emergency exception to the general requirement for informed consent. The standards for defining an emergency vary considerably but a majority of cases involving psychiatric emergencies require a showing that there has been a professional judgment in taking at face value a person's request for admission to a hospital for medical treatment, it may not be justified in doing so, without further inquiry as to a mentally ill person's request for admission and treatment at a mental hospital." Id. at 133, n.18.

18See, e.g., Canterbury v. Spence, 464 F.2d 771 (D.C. Cir., 1972), cert. denied, 409 U.S. 1064 (1972), the court described an emergency as "when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment". Id. at 788 (citing cases in n.91). In Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980), a district court struck down a state mental hospital's practice of freely administering antipsychotic drugs to patients against their will. The court ruled, however, that when the hospital has "at least probable cause to believe that a patient is presently violent or self-destructive, and in such condition presents a present danger to himself, other patients or the institution's staff," the hospital could forcibly administer antipsychotic drugs. Id. at 935 (emphasis in original).

In Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (en banc) a three-judge plurality of the Third Circuit wrote that "antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to protect the patient from endangering himself or others." Id. at 269. See also id. at 274 (Seitz, C.J. concurring).

In Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985), the Tenth Circuit held that a pretrial detainee has a constitutionally-derived liberty interest in avoiding unwanted medication with antipsychotic drugs, but that this interest must be balanced against the state interests of maintaining security and "preventing a violent and dangerous mentally ill prisoner from injuring himself and others." Id. at 1394. The Tenth Circuit further held that, while forcible medication with antipsychotic drugs may be required in an emergency, the decision that an emergency exists "must be the product of professional judgment by appropriate medical authorities, applying acceptable medical standards." Id. at 1395-96.

The Supreme Court of Colorado, in People v. Medina, 705 P.2d 961 (Colo. 1985) permitted forced medication in an emergency "that poses an immediate and substantial threat to the life or safety of the patient or others in the institution." Id. at 963. The Supreme Court of Wisconsin in State ex. rel. Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987) held that psychotropic drugs can be forced on an individual only if the individual has been found to be incompetent or if medication "is necessary to prevent serious physical harm to the patient or to others." Id. at 894.


19There is some authority which suggests that there should be no deference to professional judgment when the patient is competent. See, e.g., Williams v. Wilzack, 573 A.2d 809 (Md. 1990). The United States Supreme Court's decision in Washington v. Harper, 494 U.S. 210 (1990) supports the conclusion that the Court is maintaining its deference to professionals, at least in a prison setting, where medication and treatment issues are under consideration. See infra notes 24-25.
that medication is necessary to prevent a high level of imminent risk to the physical safety of others.

The Seventh Circuit recently reviewed the applicability of the emergency exception in a community psychiatric treatment setting in Sherman v. Four County Counseling Center. Paul Sherman had been brought to the Four County Counseling Center, a community mental health facility with a small in-patient unit for emergency psychiatric treatment. The emergency detention ordered the center to give Sherman "whatever treatment is deemed necessary and appropriate with or without the consent of the Respondent." Sherman was treated with psychotropic medication against his will and transferred to a state hospital. Approximately two weeks later a judge determined that the involuntary commitment had not been justified and ordered Sherman's release.

Sherman sued the Four County Counseling Center for violation of his constitutional rights in forcing him to accept medication. The court held that the mental health center (a private corporation) was entitled to the qualified immunity from suit generally accorded to public officials, in part because the center was fulfilling a public duty in providing treatment for persons in a psychiatric emergency. The court concluded that

Four County's staff believed Sherman was hostile and dangerous and in need of medication. ... In the context in which it acted - medicating an apparently schizophrenic patient in emergency detention - we cannot say that Four County's actions were unconstitutional, much less egregious as to bar Four County's assertion of qualified immunity.

2. Involuntary Confinement

Involuntary commitment, without more, does not justify imposing medication without consent. In cases involving persons who have been involuntarily committed, a majority of the courts have permitted the state to override the individual's refusal to accept medication after an impartial

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20987 F.2d 397 (7th Cir. 1993).
21 Id. at 405.
22 Id.
23 Id. at 409-10.
medical review. In Rennie v. Klein the Third Circuit essentially affirmed its earlier en banc conclusion that a system of professional review within the hospital was a sufficient level of protection to overcome an involuntary patient’s refusal to be medicated. The Rennie court’s decision is consistent with decisions of the United States Supreme Court which have been giving increasing deference to professional judgment when balancing competing interests of individual rights and the state either as parens patriae or in the exercise of police powers. On balance, it appears reasonable to assume that

25See, e.g., Washington v. Harper, 494 U.S. 210 (1990); Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980); Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); In re Burton, 464 N.E.2d 530 (Ohio 1984). But see the following cases: The Tenth Circuit in Walters v. Western State Hosp., 864 F.2d 695 (10th Cir. 1988) held that a civilly committed patient who is legally competent has an absolute right to refuse medication, except in emergency. Accord, Riese v. St. Mary’s Hosp. and Medical Ctr., 243 Cal. Rptr. 241 (Cal. Ct. App. 1988), cause dismissed, 443 N.W.2d 824 (Minn. 1989); State ex. rel. Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987). In Williams v. Wilzack, 573 A.2d 809 (Md. 1990), the court declared that the statute governing forced medication was unconstitutional despite the requirements of an impartial medical panel to review the facts since there was no notice, no opportunity to confront and cross examine witnesses or to have an expert adviser, and no opportunity for judicial review. Id. at 802-21.


27In 1981 the Third Circuit had ruled that there was a constitutional right to refuse treatment and that treatment had to occur through the least intrusive means. Rennie v. Klein, 653 F.2d 836 (1981). The Third Circuit further held that due process was satisfied by the provisions of a state administrative procedure for review of orders for forced medication. Id. 653 at 851. The United States Supreme Court reviewed the Rennie decision and remanded the case for review in light of their decision in Youngberg v. Romeo, 457 U.S. 307 (1982).

28See, e.g., Youngberg v. Romeo, 457 U.S. 307 (1982); Parham v. J.R., 442 U.S. 584 (1979). This approach was reaffirmed in Washington v. Harper 494 U.S. 210 (1990) in which the Court held that due process was satisfied where the prison inmate’s treatment was ordered by a competent physician to protect the inmate or others, and the inmate could challenge the doctor’s opinion in a hearing before a panel of doctors and prison administrators. Id. at 225-27. The Court explicitly rejected the requirement of judicial review. Id. at 231. In so doing, the Court disapproved of the holding in United States v. Charters, 829 F.2d 479 (4th Cir. 1987), different results reached on reh’g, en banc, remanded, 863 F.2d 302 (4th Cir. 1988), cert. denied, 494 U.S. 1016 (1990) in which the Fourth Circuit had held (in its original decision) that, absent an emergency, the following principles apply:

If the court determines that Charters is medically competent, he must be permitted to refuse antipsychotic medication. In making the determination of medical competence, the court should evaluate whether Charters has followed a rational process and can give rational reasons for his choice to refuse antipsychotic medication; (3) If the court determines that Charters is not medically competent, it should determine whether there is clear and convincing evidence of what Charters would do if he were competent; (4) If a substituted judgment
a state regulation which requires an impartial medical review will be sufficient to satisfy the requirements of due process in overcoming the right to refuse treatment.

3. Guardianship

The general rule is that, once a person has been declared incompetent, the guardian becomes responsible for making treatment decisions on the individual’s behalf. Most cases require a specific finding that the person is incompetent to make decisions on treatment.29

An Ohio appellate court in In re Guardianship of Willis30 ruled that a guardian has the authority to consent to the use of psychotropic medication when the guardian has determined that the medication is in the ward’s best interest. In that case the Franklin County Probate Court entered a general order for guardianship with a separate authority for medical care. The original order was entered while the ward was in a psychiatric hospital and refusing to accept medications. The court of appeals observed that:

Ohio Revised Code 5122.271 provides under certain circumstances that the patient must be allowed to make an informed intelligent decision. However, if the patient is declared an incompetent, then she is presumed unable to make an informed decision and the guardian and/or court is authorized to make it for her.31

The court then stated that the guardian’s authority to force medication could be based on the guardian’s judgment as to the best interest of the ward; there was no need to show that the ward was dangerous to self or others.32 The court of appeals concluded:

The bottom line is that appellant suffers from a manageable form of mental illness. On two occasions, the court has concluded that she is incapable of making an informed decision regarding her own physical and emotional well-being. If appellant is permitted to continue to refuse medication, her family will most probably disintegrate. Medical

cannot be made, the court should order forcible medication only upon finding that it is in Charters’ best interests.

829 F.2d at 499–500. On remand, the Fourth Circuit concluded that an impartial review procedure was sufficient to protect individual interests in due process. 863 F.2d at 309-12. See also, Johnson v. Silvers, 742 F.2d 823 (4th Cir. 1984).

29 See, e.g., Rogers v. Commissioner of Dep’t of Mental Health, 458 N.E.2d 308 (Mass. 1983) (court requires that the guardian make a decision on medication which the ward would have made if the ward were competent); 458 N.E.2d. 316; Riese v. St. Mary’s Hosp. and Medical Ctr., 243 Cal. Rptr. 241 (Cal. Ct. App. 1st Dist. 1987); Sanders v. New Mexico Health and Env’t Dep’t, 773 P.2d 1241 (N.M. 1989).


31 Id. at 746-47.

32 Id.
science has the tools to permit appellant to lead a relatively normal life and her family appears to love and support her. Her present condition makes it impossible for her to understand the implications of her decision. Given the relatively minor invasion of her privacy and the much greater benefits gained by the invasion, it is in appellant's best interest to have a guardian appointed with the power to authorize the forced administration of psychotropic drugs.  

III. OHIO PROCEDURES FOR ACCESS TO TREATMENT

A. Voluntary Treatment

A person receiving treatment on a voluntary basis retains maximum control over the course of treatment, particularly on an out-patient basis. Voluntary treatment in the community, in general, is not subject to any specific statutory procedures. Procedures for voluntary admission to a hospital are found in Ohio Revised Code section 5122.02.  

1. Procedures for Voluntary Admission

Any competent adult may seek voluntary treatment at any mental health facility. A guardian may admit a ward as a "voluntary" patient to an in-patient setting, although a procedure is available to challenge such an admission. The Alcohol, Drug Addiction and Mental Health Services Board ("ADAMH Board") of the applicant's county of residence must give advance approval to all voluntary admissions to public hospitals.  

2. Rights of Competent Persons Receiving Voluntary Treatment

Ohio statutes and regulations incorporate the principle that legally competent persons are generally required to give informed consent to treatment decisions. Ohio Revised Code Chapter 340 requires that ADAMH Boards establish a system of services which includes, as an essential component, "protection of the rights of consumers of mental health services." Section 5122:2-1-02 of the Ohio Administrative Code enumerates the rights of clients of contract mental health service agencies or community mental health planning boards.  

33Id. at 748.

34Minors over the age of 14 may receive mental health services, other than medication, without consent of their parents for a limited period under OHIO REV. CODE ANN. § 5122.04 (Baldwin 1993).

35The United States Supreme Court in Zinermon v. Burch, 494 U.S. 113, 140 (1990), emphasized that "voluntary" admissions can only be made with knowing and intelligent consent by a person who has the capacity to consent.

36OHIO REV. CODE ANN. § 5122.02(C) (Baldwin 1993).

37OHIO REV. CODE ANN. § 5122.02(B) (Baldwin 1993).

38OHIO REV. CODE ANN. § 341.03(A) (9) (j) (Baldwin 1993).
health boards. These rights include "the right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;"\(^{39}\) "the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;"\(^{40}\) and "the right to freedom from unnecessary or excessive medication."\(^{41}\) Likewise, Ohio Administrative Code section 3793:2-1-07 details the rights of clients of alcohol and drug addiction out-patient treatment programs, including "the right to give consent or to refuse any services, treatment, or therapy."

Ohio Administrative Code section 5122-27-05 requires mental health agencies to have policies and procedures for obtaining the informed consent for treatment from persons served and/or their parents or guardians when appropriate. These policies and procedures must explain the risks and benefits of each proposed treatment, alternative treatment, and of no treatment at all. They must also delineate the agency's response to client refusal which is to include (a) a reaffirmation of the client's right to refuse treatment, (b) efforts to collaborate with the client on alternative treatment approaches, and (c) efforts to ensure client appreciation for the potential consequences of failure to consent to treatment.

B. Involuntary Commitment

Involuntary commitment can be achieved through two basic means: emergency admission and admission by order of probate court. In general, a probate court must commit an individual to an ADAMH Board or to an agency designated by the ADAMH Board. The probate court has authority to make the commitment but does not have the authority to impose details of treatment. The ADAMH Board or designated agency has discretion to alter placement within the community; placement in an in-patient setting requires filing of a motion. Rights of individuals who have been committed are generally defined in Chapter 5122 and in applicable cases. Such persons have a limited right to refuse treatment.

1. Emergency Admission

An emergency admission may be effectuated under Ohio Revised Code section 5122.10 when a person is mentally ill subject to hospitalization by court order and is presenting substantial risk of physical harm to self or others if not confined at once.\(^{42}\) All emergency admissions must be reviewed by the ADAMH Board to determine whether the criteria for admission are met and


\(^{42}\)The procedures and test for emergency admissions is discussed in In re Miller, 585 N.E.2d 396 (Ohio 1992).
whether there is any less restrictive alternative. The maximum duration of an emergency admission is three court days, after which the hospital must either discharge the person, admit the person as a voluntary patient, or file an affidavit in Probate Court to initiate civil commitment proceedings.

2. Initiating Commitment through Probate Court

Probate court commitments must begin by filing an affidavit which shows that the individual is mentally ill and subject to hospitalization by court order. All affidavits must be reviewed by the ADAMH Board to determine whether the criteria are met and whether there is any less restrictive alternative. The ADAMH Board has the duty to show, by clear and convincing evidence, that the individual is mentally ill and is subject to hospitalization by court order as those terms are defined in the statute. Rights of the person being committed are listed in §5122.15, which includes the right to counsel and the right to an independent expert at state expense, if the person is indigent.

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44 Ohio Rev. Code Ann. § 5122.05(A) (Baldwin 1993).

45 Mental Illness is defined in Ohio Rev. Code § 5122.01(A) as:

[A] substantial disorder in thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

A mentally ill person is subject to hospitalization by court order under Ohio Rev. Code § 5122.01(B) if that person, because of his or her illness, meets any of the following criteria:

1. Represents a substantial risk of physical harm to himself [or herself] 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 himself [or herself] as manifested by evidence that he [or she] is unable to provide for and is not providing for his [or her] basic physical needs because of his [or her] mental illness and that appropriate provision for such needs cannot be made immediately available in the community; or

4. Would benefit from treatment in a hospital for his [or her] 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 himself [or herself].

Ohio Rev. Code Ann. § 5122.01(B) (Baldwin 1993).

3. Probate Court Commitment Orders

If the probate court finds that the commitment criteria are met, it may order the individual to any of the following:

a. ADAMH Board or designated agency,
b. private hospital,
c. V.A. hospital,
d. to receive private psychiatric or psychological care and treatment, or
e. any other suitable setting.

The respondent has the right to be placed in the least restrictive setting appropriate to treatment goals. The court may make an order to the ADAMH Board or designated agency regardless of consent of the Board or agency or the availability of space. Other placement orders require consent of the facility or person to accept the placement.

The probate court does not have authority to define conditions of confinement or details of treatment once the court has selected one of the alternatives listed above. In State v. Lanzy the lower court had ordered that the involuntarily committed patient not be permitted to leave the locked ward without being accompanied by a security guard. The Court of Appeals for the Eighth District held that the trial court had no statutory authority under Chapter 5122 to enter orders which govern the details of the patient's confinement or treatment. While the Lanzy decision applies to persons after being found NGRI, the reasoning probably applies to persons who are committed through the civil system.

4. Post-Commitment Procedures

a. General

If a commitment is made to an ADAMH Board or designated agency, the Board or agency must ensure that the individual is treated in the least restrictive

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47 The ADAMH Board or designated agency decides on the least restrictive placement for an individual after the commitment. This differs from the procedure in many states in which the court makes the decision regarding the least restrictive alternative. Geraldine A. McCafferty & Jeanne Dooley, Involuntary Outpatient Commitment: An Update, 14 MENTAL & PHYS. DISAB. L. REP. 277 (May/June 1990).


51 Medication orders are an exception. See infra Part III(B) (6) (a).


53 Id. at 1152.

54 Id. at 1154.
setting throughout the time that he or she continues to meet the criteria for commitment. Placement may be made by the ADAMH Board or its designated agency in a hospital or community setting without further court order. The chief clinical officer of the Board or agency must examine patients every 30 days to determine whether commitment is appropriate and placement is justified.

b. Trial Visits from Hospital

"When the chief clinical officer of a hospital considers it in the best interest of a patient, he [or she] may permit the patient to leave the hospital on a trial visit." The duration of the visit is at the discretion of the chief clinical officer, but is limited to ninety days. The period may be extended for additional ninety day terms after evaluation of the patient's condition each ninety days. The maximum duration of a trial visit is one continuous year.

During the trial visit period, the chief clinical officer may impose requirements and conditions which are consistent with the treatment plan. The trial visit may be revoked without notice or court approval if the chief clinical officer finds that return to the hospital is in the best interest of the patient. If the revocation of the trial visit is not voluntarily complied with within five days, the chief clinical officer must authorize a health or police

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56. "Chief clinical officer" means the medical director of a hospital, or a community mental health agency, or a board of alcohol, drug addiction, and mental health services, or, if there is no medical director, the licensed physician responsible for the treatment a hospital or community mental health agency provides. The chief clinical officer may delegate to the attending physician responsible for a patient's care the duties imposed on the chief clinical officer by this chapter. Within a community mental health agency, the chief clinical officer shall be designated by the governing body of the agency and shall be a licensed physician or licensed clinical psychologist who supervises diagnostic and treatment services. A licensed physician or licensed clinical psychologist designated by the chief clinical officer may perform the duties and accept the responsibilities of the chief clinical officer in his or her absence. Ohio Rev. Code Ann. § 5122.01(K) (Baldwin 1993).


59. If the patient has been found not guilty by reason of insanity "NGRI", court approval of any trial visit is necessary. Lanzy, 504 N.E.2d 1150 (Ohio Ct. App. 1985).

60. "Id.

61. If an involuntarily committed patient has successfully completed one year of continuous trial visit, the chief clinical officer shall discharge the patient. Ohio Rev. Code Ann. § 5122.22 (Baldwin 1993).

62. "Id.

officer or sheriff to take the patient into custody and transport him or her to the hospital.\footnote{64}{Id.}

In \textit{Matter of Plummer},\footnote{65}{608 A.2d 741 (D.C. App. 1992).} the District of Columbia Court of Appeals held that a person placed on extended convalescent leave (a status between in-patient commitment and out-patient commitment) is entitled to the same due process rights as a patient who is originally committed as an out-patient.\footnote{66}{Id. at 743.} The Court stated that release of such an individual "for an indefinite period of time" makes that person a de facto out-patient.\footnote{67}{Id. at 744.} Such a person possesses an interest in not being deprived of his or her freedom to remain in the community without due process safeguards.\footnote{68}{Id. at 744. The due process rights required by the court include the following: the hospital superintendent must provide the court with an affidavit within 24 hours of the patient's return to the institution; the court must make a prompt, ex parte determination that the patient failed to comply with the treatment conditions imposed on the leave or that the patient's condition has deteriorated; the patient's attorney must be provided with a copy of the affidavit within 24 hours; and the patient and his or her attorney must be notified in writing of the patient's right to release or hearing. \textit{Id.}} The trial visits authorized by Ohio law are distinguishable from convalescent leave addressed in \textit{Plummer} because they are time limited leaves.\footnote{69}{\textit{Ohio Rev. Code Ann.} § 5122.22 (Baldwin 1993).} The constitutionality of the procedures for revocation of trial visits has not been reviewed by a court in Ohio.

c. Transfers within the Community

If a person who has been involuntarily committed is placed in the community and is being transferred to another setting within the community, the ADAMH Board or agency must first consult with the individual about the intended placement.\footnote{70}{\textit{Ohio Rev. Code Ann.} § 5122.15(N) (Baldwin 1993).} If the person objects, a qualified mental health professional, not otherwise involved in treatment of the client, must review the proposed placement, and the need for proposed placement.\footnote{71}{Id.} If the independent reviewer agrees, the change in placement can be made, even if the subsequent placement is a more restrictive setting.\footnote{72}{\textit{Ohio Rev. Code Ann.} § 5122.20 (Baldwin 1993). A different procedure applies if the probate court has made a placement to a specific facility or therapist in the community. If the court has entered such an order, and the chief clinical officer determines that transfer to a more restrictive setting is in the best interests of the patient, the chief clinical officer must file a motion with the court requesting a change in the placement order. A hearing is held only on the patient's request.}
The ADAMH Board or agency may, without consent, transfer a person under commitment from the community to a hospital only if there is a determination that the person is in immediate need of treatment in an in-patient setting because the person represents a substantial risk of physical harm to self or others if allowed to remain in a less restrictive setting. On the day of placement or on the next court day, the ADAMH Board or agency must either file a motion with the court for a transfer to an in-patient setting, or notify the court by telephone that the required motion has been mailed. A hearing on the motion is held only on request of the person being transferred.

The constitutionality of this provision of Ohio law has not been reviewed by an Ohio court. However, several courts in other states have held that revocation of conditional discharge, which is analogous to out-patient commitment in Ohio, requires a prerevocation hearing except in the case of an emergency. The Vermont Supreme Court, in G.T. v. Stone, found that Vermont's statute governing rehospitalization of patients on conditional release or conditional leave did not adequately protect the patients' rights. The Vermont statute allowed readmission to the hospital without a prior hearing, and required a post-recommitment hearing only upon request of the client. The court found that federal constitutional standards required

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74 OHIO REV. CODE ANN. § 5122.15(M) (2) (Baldwin 1993).
75 OHIO REV. CODE ANN. § 5122.15(M) (4) (Baldwin 1993).
76 G.T. v. Stone, 622 A.2d 491 (Vt. 1993); In re Plummer, 608 A.2d 741 (D.C.App. 1992); Lewis v. Donahue, 437 F. Supp. 112 (W.D. Ok. 1977). These cases analogize conditional release from a mental institution to parole from prison, and rely on the Supreme Court's logic in Morrissey v. Brewer, 408 U.S. 471 (1972). But see, In re True, 645 P.2d 891 (Id. 1982). The Supreme Court of Idaho found that "reliance on the criminal analogy is suspect in determining what process is due such a [conditionally released] individual." Id. at 902 (McFadden, J.). The court held that the minimal due process necessary to rehospitalize a conditionally released patient included a determination that the conditions warranting hospitalization in the first instance are again present, prompt written notice to the patient of the reasons for and evidence relied upon to justify the rehospitalization, notice of the patient's right to challenge the allegations, and a hearing before a neutral hearing body held as soon as possible following the patient's rehospitalization. Id. at 894. The court recognized that revocation of the conditional release was not an isolated event, but was part of a sequence of confinement and treatment. The entire course of treatment rather than one isolated event in the treatment must be measured against the Due Process Clause. Id. at 900, quoting Dietrich v. Brooks, 558 P.2d 357, 361 (1976).
77 622 A.2d 491 (Vt. 1993).
78 Id. at 494.
79 Id.
a judicial hearing prior to recommitment, whether or not requested by the patient, unless immediate recommitment is required because the person poses an imminent danger of harm to self or another. In cases of immediate recommitment, a hospital staff member familiar with the person’s case and current circumstances must state in the recommitment order the specific facts which give rise to the imminent danger, and a constitutionally adequate hearing must be initiated promptly thereafter.  

5. Rights of Persons Subject to Involuntary Commitment

a. General Rights

Persons who are committed under Chapter 5122, including persons admitted on an emergency basis or pursuant to probate court order, retain all civil rights, unless those rights are specifically removed by a court order other than an order of commitment. Persons being treated for drug or alcohol addiction also retain all civil rights. These principles have been affirmed in numerous decisions.

Ohio Revised Code sections 5122.27 and 5122.29 list the broad rights guaranteed any person who has been hospitalized or committed under Chapter 5122. Ohio Revised Code section 5122.27 focuses on treatment rights while Ohio Revised Code section 5122.29 enumerates broader civil protections, including, but not limited to, the rights:

1. to be treated with consideration and respect for his or her privacy and dignity.
2. to be given reasonable protection from assault or battery by any other person.
3. to communicate freely with others and to receive visitors at reasonable times, unless specifically restricted in the patient’s treatment plan for clear treatment reasons.
4. to reasonable privacy, including both periods of privacy and places of privacy.
5. to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient’s written treatment plan for clear treatment reasons.

80 Id.
83 See supra notes 24-28 and accompanying text.
85 Id.
b. Informed Consent Requirements for Persons Involuntarily Committed under State Law

State law and regulations require the informed consent of consumers of mental health services who are competent. Ohio Revised Code section 5122.271(A) states that persons in hospitals under Chapter 5122 must be given sufficient information to allow them to "give a fully informed, intelligent and knowing consent," for care. The court in In re Guardianship of Willis acknowledged that this section allows a competent patient to refuse medication. Persons committed under Chapter 5122 are entitled to be "free from unnecessary or excessive medication.

Persons who are receiving treatment involuntarily in the community have the same basic rights under State law and regulations as do persons receiving voluntary treatment, which are described in section III.A.2 above. Involuntary treatment in the community, however, may afford lesser rights to refuse treatment than involuntary hospitalization, because compliance with treatment orders is generally a condition of the community placement which must be followed to avoid in-patient placement.

c. Ohio Department of Mental Health ("ODMH") Policy on Informed Consent

In 1987 ODMH issued a policy statement which defined procedures for informed consent in psychiatric hospitals operated by ODMH. The policy reaffirmed the principle that medication should not be given without informed consent to any person, with or without a guardian, who has the capacity to make decisions about treatment. The policy allowed forced medication under two circumstances: emergencies and when the patient was found, after review, to lack the capacity to make an informed decision. When there

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88 Id. at 746.
89 Ohio Rev. Code § 5122.27(F) (Baldwin 1993).
90 ODMH Policy on Informed Consent.
91 The policy was promulgated prior to the decision in Guardianship of Willis, 599 N.E.2d 745, 746 (Ohio Ct. App. 1991). This decision probably overrides those provisions of the policy which permit a ward to refuse medication despite a guardian's recommendation to the contrary.
92 "Emergency" is defined as "an impending or crisis situation which creates circumstances demanding immediate action for preservation of life or prevention of serious bodily harm to the person or others as determined by a licensed physician or registered nurse." ODMH Policy on Informed Consent § C(1).
93 "Lack of Capacity" is defined as "the inability due to mental impairment to make reasoned decisions regarding the taking of medication, by evaluating information about the likelihood of therapeutic benefit, the risk of side effects and the availability of alternative treatments." ODMH Policy on Informed Consent § C(5).
is a question as to whether a patient who refuses to consent to medication lacks capacity, the hospital may initiate a review process which includes:

- a panel of three persons not connected to the patient's treatment who determine whether the patient has the capacity;
- if a majority of the panel finds that the person lacks capacity, the treatment team must review the decision to medicate in light of specified factors;
- if the team decides to force medication, there is automatic review by the hospital's medical director or independent review panel of persons within the hospital who are not involved in the treatment plan;
- if the medical director decides to force medication, the patient may appeal the decision to the medical director of ODMH.

In 1989, the Franklin County Court of Common Pleas issued an injunction against forcible medication under the policy in *Cleveland et al. v. Ohio Department of Mental Health.* This injunction was dissolved in 1992 by the Ohio Court of Appeals for the Tenth District, apparently leaving the policy in place.

6. Probate Court Authority

a. Medication Decisions

The legislature has granted probate courts specific authority to enter orders regarding medication, although the circumstances for exercise of this authority have not been fully defined. In 1991 the legislature amended the jurisdiction of probate court to include the power to "hear and determine actions involving informed consent for medication of persons hospitalized pursuant to sections 5122.141 and 5122.15 of the Revised Code." Prior to the passage of this amendment, the court in *Cleveland et al. v. Ohio Department of Mental Health,* observed in its opinion that "absent an emergency as defined by the Policy and during the pendency of this Order, the Defendants may seek a judicial order pursuant to Ohio Rev. Code §5122.271 if they wish to forcibly medicate plaintiffs or members of Plaintiff class." In dissolving the injunction the court reasoned, in part, that the 1991 amendments which vested exclusive jurisdi-

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94 No. 89-CV-3658 (Franklin Cty. C.P. 1989).
95 Cleveland v. Ohio Dep't of Mental Health, 618 N.E.2d 244 (Ohio Ct. App. 1992), motion to certify overruled, 613 N.E.2d 239 (Ohio 1993).
96 Ohio REV. CODE ANN. § 2101.24(A) (1) (t) (Baldwin 1993).
97 No. 89-CV-3658 (Franklin Cty. C. P. 1989) (see summary in part III.B.5.c)
98 Id.
tion in a probate court to enter orders on medication removed authority from a common pleas court to continue the injunction.\(^9\)

These cases strongly suggest that the probate court does have the power to enter orders on medication in civil commitment cases. The use of the term "hospitalized" in section 2101.24(A) (1) (t) raises a question as to whether the power applies only to persons in a hospital. The use of the term "hospital" and "hospitalized" throughout Chapter 5122 strongly suggests that the term is co-extensive with involuntary commitment, whether or not the locus of care is in an institution. The standards for exercise of this authority in the civil commitment context, however, have not been defined.

b. Contempt Powers of Probate Court

Contempt powers of the probate court may be used to enforce compliance with a medication order. Ohio Revised Code Section 2705.02 authorizes the punishment for contempt of any individual who disobeys or resists a court order. Contempt can be civil or criminal depending upon the character and purpose of the sanction. Civil contempt proceedings are primarily designed to encourage compliant behavior and are coercive in nature. Criminal contempt proceedings are designed to vindicate the court’s authority and are punitive in nature.

Violation of a court order requiring the taking of medication may subject one to a civil contempt proceeding. A finding of contempt requires, in general, the establishment of a valid and clear court order, knowledge of the order, and a violation of the order.\(^{100}\) Where contempt is being used to enforce compliance with medication orders, the court must find, in addition, that the patient has the mental and physical ability to comply with the order.\(^{101}\)

Ohio Revised Code Section 2705.05 requires that a hearing be conducted in all contempt proceedings in order to investigate and hear testimony of the accused. Penalties for contempt may include imprisonment until the ordered act is performed,\(^{102}\) or a definite term of imprisonment and/or a monetary fine.\(^{103}\)

C. Guardianship

1. Summary of Procedure

A guardian may be appointed by the probate court when the court finds by clear and convincing evidence that an individual is incompe-

\(^{9}\) Id.


\(^{102}\) OHIO REV. CODE ANN. §2705.06 (Baldwin 1993).

\(^{103}\) OHIO REV. CODE ANN. § 2705.05 (Baldwin 1993).
tent, and that a guardian is necessary. The prospective ward has extensive due process protections, including the rights to notice in person, counsel and an independent evaluation. After the hearing, the court may direct that there be a guardian of the person, estate or both. Where the court finds that the best interests of the ward require a limited guardian, the court may enter such an order, limiting the scope or duration of the guardian’s powers. Any competent adult living in the state may act as a guardian. In general, agencies may not be guardians of the person.

2. Scope of Guardian’s Authority

a. General

A guardian of the person, or a limited guardian with appropriate powers, has the duty to "protect and control the person of his ward." The statute specifically empowers the guardian to "authorize or approve the provision to his [or her] ward of medical, health, or other professional care, counsel, treatment, or services unless the ward... files objections with the probate court...." The rules of the Ohio Department of Health on certification of Adult Care Facilities also recognize that a guardian’s decision on medication is controlling.

D. Advance Psychiatric Directives

A relatively recent means of promoting compliance with treatment during decompensation is the use of advance psychiatric directives. Often referred to as a "psychiatric living will," an advance psychiatric directive is analogous to

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104 An incompetent person is defined in Ohio Rev. Code Ann. § 2111.01(D) (Baldwin 1993):

Any person whose mental impairment caused by mental or physical illness or disability, mental retardation, or chronic substance abuse renders that person incapable of taking proper care of self or property or to provide for family or any other persons for whom that person is obligated by law to provide.

105 Ohio Rev. Code Ann. § 2111.02(A),(C) (Baldwin 1993).

106 Ohio Rev. Code Ann. § 2111.02(C) (Baldwin 1993).

107 Ohio Rev. Code Ann. § 2111.02(A) (Baldwin 1993).

108 Ohio Rev. Code Ann. § 2111.02(B) (Baldwin 1993).


110 Id.


112 Id. at § 2111.13(C).

the durable power of attorney for health care or the typical "living will" for health care decisions allowed under the Ohio Revised Code.114

The Ohio statute allows the attorney in fact appointed in a durable power of attorney for health care to make health care decisions when the principal's attending physician determines that the principal has lost the capacity to make informed health care decisions for himself or herself. The authorization may give the right to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any health care that is being provided to the principal. The "attorney in fact may make health care decisions for the principal to the same extent as the principal could make those decisions for himself [or herself]."115 The "attorney in fact is required to act consistently with the desires of the principal," if known, or in the best interest of the principal if his or her desires are not known.116

E. Criminal Justice System

1. Probation

Persons who have been convicted of a crime may be placed on probation in lieu of incarceration.117 The statute provides that the court may impose conditions on the probation consistent with the goal of rehabilitating the offender and ensuring his or her good behavior. Courts have often imposed treatment, including compliance with medication orders, as conditions for probation. Ohio Revised Code section 2951.04 authorizes the court to place offenders believed to be drug dependent or in danger of becoming drug dependent on conditional probation for purposes of treatment and rehabilitation if the offender so desires, is accepted into an appropriate program, and the court finds that he or she may benefit from such treatment. Such probation is conditioned on the offender's voluntary entrance into an appropriate in-patient or out-patient treatment program and compliance with the program's requirements.

114Most states, including Ohio, have passed general health proxy laws, which allow individuals to designate a health care decision maker to act for the principal. OHIO REV. CODE ANN. § 1337.11 et. seq. (Baldwin 1993). Minnesota has approved the use of advance medical directives specifically for psychiatric care, which would take effect whenever an individual was receiving treatment, either voluntarily or involuntarily. STAR TRIBUNE, January 17, 1992 at 1B.

The Supreme Court of New York honored a psychiatric living will which withdrew the patient's prior consent to electroconvulsive therapy. In re Rosa M., 155 Misc.2d 103, 597 N.Y.S.2d 544 (N.Y. Sup. Ct. 1991). There was no evidence that the patient was not competent at the time the writing was signed. The court stated that "a hospital or medical facility must give continued respect to a patient's competent rejection of certain medical procedures even after the patient loses competence." Id. at 104-05.


116Id.

117OHIO REV. CODE ANN. § 2951.02 (Baldwin 1993).
2. Parole

Ohio Revised Code section 2967.03 authorizes the Adult Parole Authority to grant a parole if in its judgment there is reasonable ground to believe that if the prisoner is paroled such action would further the interests of justice and be consistent with the welfare and security of society. The Adult Parole Authority has the right to prescribe the terms and fix the conditions upon which parole may be granted. "The adult parole authority may require [that] a parolee reside in a halfway house or other suitable community residential center" designated by the authority during a part of or for the entire period of the parolee's conditional release.\(^\text{118}\)

Ohio Revised Code section 2967.22 provides that whenever it is brought to the attention of the Adult Parole Authority that a parolee appears to be a mentally ill person subject to hospitalization by court order, a parole officer may, with appropriate authorization, file an affidavit to institute proceedings for the hospitalization of such parolee. The parolee would then be subject to the provisions of Chapter 5122 on civil commitment.\(^\text{119}\)

F. Other Applicable Statutes and Regulations

Several other state and federal statutes and regulations impact the ability of providers to compel compliance with treatment in the community. Most of these prevent the imposition of compliance requirements on individuals or limit the manner in which treatment compliance can be required.

1. Fair Housing Amendments Act

The Fair Housing Amendments Act "FHAA" of 1988 prevents discrimination in the sale or rental of property on the basis of handicap.\(^\text{120}\) Under the FHAA, an individual suffering from mental illness may not be denied rental of a property or evicted merely on the basis that the individual acts unconventionally or because of generalized fear on the part of the landlord or other tenants.\(^\text{121}\) An individual cannot be evicted for acting out unless those behaviors are a real threat to the health, safety, or property of others.\(^\text{122}\)

The FHAA allows a landlord to reject an applicant or evict a tenant only if the person is unable or refuses to comply with legitimate rules which are applied equally to all tenants, such as if the individual causes substantial damage to the property of others, or if the person is a direct threat to the health or safety of other tenants.\(^\text{123}\) A property owner or landlord must indicate a
direct connection between the individual's tenancy and the direct threat, which must be established on the basis of past or current conduct. For example, there must be objective evidence of prior overt, harmful or threatening actions. Subjective anxieties and speculation will not suffice to prove a direct threat. In order to determine if a prospective disabled tenant is a direct threat or is eligible for housing, a landlord or owner may ask only those questions which are directly related to the tenancy and which would be asked of any other prospective tenant. Examples of relevant questions include inquiries involving rental history or whether that prospective tenant has acted in ways that would directly threaten other tenants.\textsuperscript{124}

The landlord is required to make reasonable accommodation to the individual's disability if such accommodation would allow the person to comply with the tenancy rules or would eliminate the threat to person or property.\textsuperscript{125} For example, in a case where a person with mental illness was making excessive noise and damaging an apartment to silence voices the person was hearing, the landlord could be required to postpone eviction to permit the tenant to obtain counseling and outreach assistance.

2. Mental Health Housing Assistance Program

The Mental Health Housing Assistance Program "HAP" is an ODMH program designed to provide funds to assist persons with mental illness to obtain community rental housing. HAP funding is available only for housing which is consistent with ODMH's "Housing-as-Housing" policies.\textsuperscript{126} The Housing-as-Housing philosophy prohibits imposition of mental health service requirements on rental of HAP housing. This approach conceptually separates treatment from housing, and recognizes that the need for housing is not dependent upon the need for mental health services. "The choice to live in one's own home should not be contingent on the level and frequency of services one needs."\textsuperscript{127}

The Housing-as-Housing philosophy forbids the use of any admission criteria, house rules, on-site live-in staffing, or requirements for involvement in treatment services in HAP supported housing. Lease agreements may not contain any requirements or conditions for participation in services. The tenant assumes responsibility as in any standard landlord/tenant relationship, including liability for property damage.

3. Medicaid

Medicaid rules include a list of resident rights which apply to all long-term care facilities participating in the Medicare/Medicaid programs. These rights


\textsuperscript{125}42 U.S.C. § 3604(f) (3) (B).

\textsuperscript{126}ODMH \textit{HOUSING-AS-HOUSING DISCUSSION PAPER #07-88-29}.

\textsuperscript{127}ld.
include the right to refuse treatment,¹²⁸ and "the right to be free from any physical or chemical restraints imposed for . . . discipline or convenience, and not required to treat the resident's medical symptoms."¹²⁹ The regulations also require that residents not be given anti-psychotic drugs unless documented as necessary to treat a specific condition.¹³⁰ An effort must be made to discontinue appropriately prescribed drugs by means of "gradual dose reductions, and behavioral interventions, unless [this is] clinically contraindicated."¹³¹

4. Ohio Department of Health Regulations

The regulations governing adult care facilities licensed by the Ohio Department of Health guarantees to residents of such facilities the right to refuse medical treatment or services,¹³² and further guarantees that the residents will not be deprived of any legal rights solely because of residence in the facility.¹³³ An adult care facility may discharge a resident, however, if the mental or emotional condition of the resident requires a level of care beyond that available at the facility, or if the resident presents a threat to the health, safety or welfare of the resident or other residents of the facility.¹³⁴

IV. STRATEGIES FOR INTERVENTION

A. Introduction

The following procedures offer practical alternatives for enhancing the success of out-patient placements. Several general principles must be kept in mind in assessing the value of any particular approach:

The treatment approach which most fully includes the consumer's knowledge and consent is most likely to succeed in the long term.

Limits on a consumer's choice should be imposed only as a last resort after other means have been tried.

Intervention strategies should interfere with choice only to the extent which is necessary to effectuate legitimate treatment goals.

¹²⁸ 42 C.F.R. § 483.10(b) (4) (1992).
¹³³ Id. at § 3701-20-23(B) (17).
No single strategy or group of strategies will work in all cases. The hope is to maximize the potential for successful treatment and full autonomy, but not necessarily to solve all possible problems.

B. Development of ADAMH Board Policy

The ADAMH Board should develop a policy which establishes a procedure for informed consent, including circumstances which will justify forced medication. The policy should include persons who are committed and placed in out-patient settings, persons who are under guardianship and persons who are receiving treatment as a condition of probation. The policy should reflect the standards and principles set forth in part II.A.

C. Guardianship

1. Discussion

A guardian of the person or a limited guardian with authority to impose treatment and/or medication orders is a practical and relatively simple method for ensuring compliance with treatment either in or out of the hospital for persons who are not competent. The court's authority to enter an order for medication is reasonably clear and well-established in Ohio. A potential ward has full due process protection prior to the appointment of a guardian and can contest individual decisions at any time. The primary difficulty is in finding a suitable person who is willing to take on the responsibility for treatment decisions and who will exercise a guardian's authority in a responsible manner.

2. ADAMH Board/Agency Strategy

The ADAMH Board should develop a system which will make guardians available when an individual is incompetent and is refusing medication. Assuming a suitable guardian is found, the individual must file an application for letters of appointment as guardian of the person or as a limited guardian with powers necessary to ensure that treatment is obtained. The application for guardianship should be prepared with medical evidence showing that the potential ward is incompetent, and not solely because he or she is refusing necessary procedures or medication.

If experience shows that there are too few suitable persons willing and able to become guardians, the ADAMH Board or ODMH should consider funding an agency which will hire one or more individuals to provide guardianship services for persons in the system. There would have to be adequate provision for independence of the guardian's judgment and protection against liability. Advocacy and Protective Services is a comparable group which has been

135 A guardianship cannot be obtained for an individual who is competent but who is simply refusing medication. See supra discussion in part III.C.1.
offering guardianship services for persons with mental retardation throughout the state for the past ten years.136

D. Community Placement and Civil Commitment

1. Discussion

Civil commitment offers a measure of control over persons who meet the criteria for involuntary hospitalization but who do not need an in-patient setting. As a general strategy the ADAMH Board could emphasize the continuation of commitment status for persons even after they are discharged from an in-patient setting, provided that they continue to meet the criteria for involuntary commitment. The ADAMH Board could also use civil commitment procedures for persons who are in the community and who meet the criteria for involuntary commitment but who do not need in-patient care. Such an approach would make the strategies listed below available.

Several problems concerning the use of out-patient placement of the involuntarily committed in Ohio exist. The problem most often voiced is that the statute "lacks teeth" and that the treatment conditions attached to the community placement are unenforceable without the threat of hospitalization. An individual receiving involuntary out-patient services may be returned to the hospital without a prior court hearing only in an emergency situation, which places the individual in the same position as he or she would have been if there was no commitment order. Another concern frequently raised is the liability of an ADAMH Board or agency if individuals are not carefully selected for community placement. An ADAMH Board should carefully draft a policy which lists the factors which must be considered prior to out-patient placement.137 A final concern is the change of the function of the case manager in an out-patient commitment from an advocate of the client to a police officer who must monitor compliance with treatment.

2. Transfer to a more structured setting in the community

Persons who have been committed to the ADAMH Board or designated agency and who have been placed in the community may be moved to a more structured setting within the community without additional court

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136 Advocacy and Protective Services has special legislative authority to act as a guardian for persons with mental retardation. OHIO REV. CODE ANN. §§ 2111.10, 5123.58 (Baldwin 1993).
137 Many states list the factors which must be considered for outpatient placement in their statutes. See, e.g., ARIZ. REV. STAT. ANN. § 36-540 (1993), HAW. REV. STAT. § 334-121 (Supp. 1992). The most commonly utilized factors are the individual: will be more appropriately treated in an out-patient setting; has adequate supports in place to survive safely in the community; has a history of hospitalization or treatment which indicates a need for continuing treatment to prevent further deterioration which predictably leads to dangerousness to self or others; lacks the ability to make an informed decision to voluntarily seek or comply with recommended treatment.
involvement. If the person objects, the matter must be reviewed by a professional who is not a part of the treatment team.\textsuperscript{138}

If a person is non-compliant and their behavior is deteriorating, transfer to a more structured setting may be a means of averting a more serious crisis. This strategy assumes that there are one or more structured treatment settings available in the community.

3. Threat of transfer to an in-patient facility

Ohio statutes clearly do not permit hospitalization of an individual on out-patient commitment solely because a person is refusing medication.\textsuperscript{139} Persons may be warned of the consequences of non-compliance with medication over the long term, but a threat to commit summarily would be inappropriate.

When out-patient commitment is used for those individuals who persistently lack insight into their condition and likewise lack the judgment to make good treatment decisions, whose ability to function regularly improves significantly when treated, but who regularly decompensate and become a substantial danger to themselves or others when allowed to refuse treatment, failure to comply with treatment for a short period of time may meet the test of Ohio Revised Code section 5122.15(M) (1).\textsuperscript{140}

4. Treatment orders

The probate court has the jurisdiction to enter orders on medication for persons who are hospitalized under Chapter 5122.\textsuperscript{141} Under the most narrow interpretation of the court's authority, it can issue orders for persons who were hospitalized and discharged to the community but are still within the commitment criteria. Under a broader interpretation, the court could make medication orders for all persons who are civilly committed, even if they were not hospitalized during the commitment.

The procedures for obtaining a medication order are not specifically defined at present. A simple motion citing the statute and the facts which support the order should be adequate.

\textsuperscript{138}See supra part III.B.4.c.

\textsuperscript{139}See supra part III.B.4.d.

\textsuperscript{140}As determination must be made that the individual is in immediate need of treatment in an in-patient setting because the respondent represents a substantial risk of physical harm to self or others if allowed to remain in a less restrictive setting. \textit{OHIO REV. CODE ANN.} § 5122.15(M) (1) (Baldwin 1993).

\textsuperscript{141}See supra part III.B.6.a.
5. Contempt

Failure to abide by a court’s medication order or other treatment requirements may subject a person to a civil contempt proceeding. There must be a clear court order and a clear violation of the order. The person involved must have the mental capacity to realize that he or she is disobeying the order and must have the practical ability to comply. Contempt proceedings should be used only as a last resort.

E. Trial Visits from an In-patient facility

1. Discussion

Placement on a trial visit allows the hospital to maintain control over a patient in the community for an extended period of time and may provide a useful means of integrating some persons into the community who have had difficulty adjusting in the past. An in-patient facility may place a person on a trial visit for up to one continuous year subject to whatever conditions (including compliance with medication) that the hospital chief clinical officer deems to be in the best interest of the patient. The person’s status must be evaluated at least every 90 days. Under the Ohio statute, these trial visits may be summarily terminated and the person can be returned to the hospital without the need for meeting emergency criteria or prior court intervention.

2. ADAMH Board/Agency Strategy

The use of trial visits would have to be coordinated with the hospital administration taking into account the impact of such a practice on census limits and reimbursement rules.

F. Advance Psychiatric Directives

1. Discussion

Advance psychiatric directives should be a useful tool for clients who are compliant with treatment or medication orders when their condition is stable, but who resist treatment when their condition deteriorates. Execution of a valid durable power of attorney for health care which meets the requirements of Ohio law and which specifically addresses the medication and/or psychiatric treatment which the individual consents to in the event of decompensation, or which gives the attorney in fact full power to make decisions about psychiatric treatment for the individual should serve as valid consent for the treatment if the individual’s physician will certify that the individual lacks the capacity to make informed health care decisions. Treatment would be voluntary during periods of incapacity because of the prior consent, even if done involuntarily at the time.

142 See supra part III.B.6.c.
Use of advance psychiatric directives should give clients a feeling of greater control over their treatment, since an individual can be appointed who is trusted to make decisions in the client’s best interest. Moreover, the directives can specify preferred treatment methods, medication or treatment regimes which the client would refuse, designate a guardian if a guardian becomes necessary, and indicate the physicians preferred by the client.

2. ADAMH Board Strategy

Advance psychiatric directives should be carefully drafted to specifically apply to the psychiatric treatment of the individual executing the document. Copies of the directive should be delivered to the attorney in fact, the client’s doctors, hospital, and designated guardians. Education of clients, mental health professionals, law enforcement, and hospital personnel will be necessary to encourage acceptance and respect of these instruments.

G. Criminal

1. Discussion

Criminal courts can often provide useful incentives for persons to comply with treatment requirements due to both the range of discretion which is available for sentencing and the availability of immediate and serious sanctions for failure to meet a court order. The use of courts in this context, however, depends on a number of important factors:

- The police or sheriff must be willing to make an arrest when a crime has been committed and the prosecutor must be willing to prosecute.
- If the consumer is found guilty, the court must have reasonable assurance that there are adequate supports in place to justify an alternative to incarceration.
- The court must be willing to impose conditions for probation which are specific to the needs of the consumer and available in the system.\(^{143}\)
- Probation officers must have sufficient training to recognize the unique needs of persons with mental health or substance abuse problems.
- There must be immediate and accurate feedback to the probation officer and/or the courts if there are deviations from orders.
- Courts must be willing to impose meaningful sanctions when the conditions of probation have been violated.
- The Adult Probation Authority must be willing to impose conditions for parole which are specific to the needs of the consumer and available in the system.\(^{144}\)

Cuyahoga County has developed a Mentally Disordered Offender program which includes probation officers with special training in mental illness and

\(^{143}\text{See supra part III.E.1.}\)

\(^{144}\text{See supra part III.E.2.}\)
substance abuse as well as intensive case management support. A similar program has been successful with mentally retarded offenders.

2. ADAMH Board Strategy

Two steps must be taken to maximize the effectiveness of the criminal justice system. The ADAMH Board must ensure that a strong case management support system has been developed and that the system has some specific, viable methods for monitoring, supporting and serving offenders. The ADAMH Board must then provide comprehensive education to persons involved in the criminal justice system to ensure that they are aware of the availability of practical alternatives for persons who have been convicted and who are in need of community based services. Once the systems are in place, there should be a rigorous implementation of the conditions of probation so that the courts (and community) will develop confidence in the process.

H. Treatment as a Condition for Services

In general, services cannot be conditioned on compliance with treatment prescriptions, although a person's functioning level or behavior could affect access to services. Housing which is subsidized by ODMH funds must be offered without regard to a person's compliance with treatment recommendations. It appears unlikely that homes licensed by the Health Department can impose a requirement of treatment compliance as a condition for admission.

Structured group homes or crisis shelters which are licensed by the ODMH may be able to demand compliance to remain in the program. The licensure rules do not prohibit such a condition; the ODMH Housing-as-Housing Discussion Paper No. 07-88-29 recognizes the need for long-term or permanent group homes with 24-hour supervision and other intensive residential treatment facilities as necessary means to intervene in crises. Nothing in the paper prohibits treatment compliance as a condition for admission into these more specialized facilities.

Although compliance with treatment cannot be a requirement for residence in HAP subsidized housing, it may be possible to negotiate a reasonable accommodation with a landlord under the FHAA to forestall eviction if a resident's non-compliance is resulting in behaviors which jeopardize the client's tenancy. Such an accommodation might require a landlord to call the case manager immediately if a behavior problem becomes evident, or postpone eviction proceedings until the client has had sufficient time to obtain services.

\[145\text{See supra part III.F.4.}\]
\[146\text{Ohio Admin. Code § 5122:3-5 (1991).}\]
I. Persuasion

1. Discussion

The ability of an individual case manager or therapist to work with a person in treatment is probably the single most important resource in ensuring a successful transition to community living. Case managers are at the center of the coordination and facilitation of treatment services for persons in the community.\textsuperscript{147} They have the duty, among others, to "[e]ngage the person served to participate in the development of the individual service plan" and to "[a]ssist persons served to achieve their objectives and maximize their independence and productivity through support and training in the use of personal and community resources."\textsuperscript{148}

Continuity of care is a critical element if case management is to be successful. Case managers who know their client well are in a better position to persuade an individual consumer to participate in appropriate treatment, and can also identify the early signs of deterioration and take steps to avert decompensation to a point where more restrictive care is needed.

There are a number of models for peer-based support systems which have proven successful in assisting consumers to live in the community, locally and throughout the country. Many programs have demonstrated a higher level of compliance with medication orders as a result of these interactions.

2. Therapist strategies

A therapist who is knowledgeable about the consequences of refusing medication and who also knows a patient may be in a position to persuade the patient to accept medication. While coercion can never be condoned, a therapist is able to explain the consequences of all courses of action, including the likely possibilities of refusal.

3. ADAMH Board/Agency Strategies

- There should be specialized and intensive case management services which focus on persons who are having difficulty in adjustment.
- Case management services should emphasize continuity and follow an individual wherever he or she decides to live.
- Case managers should be able to recognize signs of non-compliance early enough so that persuasion might work.
- Encourage interaction with landlords in subsidized housing to ensure early intervention before eviction becomes the only option.
- Mobile crisis teams have proven to be effective tools to prevent re-hospitalizations.

\textsuperscript{147}OHIO ADMIN. CODE § 5122-29-17 (1991).
\textsuperscript{148}Id. at § 5122-29-17(D) (3), (5).
• Meaningful day programming can enhance compliance, either through intervention of staff or through interaction with other consumers.
• Supported employment can provide effective incentives for long-term compliance.
• Explore development of existing consumer and family support groups to assist in encouraging compliance with medication.

V. CONCLUSION

The steps outlined in this article are designed to provide tools which may be useful in at least some cases to achieve the goal of effective community based treatment for persons with mental illness. There are no easy solutions to the problem of providing optimum or even appropriate care in a community setting. There is no system which will totally eliminate deeply held prejudice against persons with mental illness or guarantee public acceptance of a community-oriented treatment system. As the momentum for community treatment builds and treatment theories become operational in the real world, however, it is hoped that the strategies described here will be useful in giving more persons being treated for mental illness a better chance at making a successful adjustment in the community.