Violence, Fear, and Jason's Law: The Needless Expansion of Social Control over the Non-Dangerous Mentally Ill in Ohio

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VIOLENCE, FEAR, AND JASON’S LAW: THE NEEDLESS EXPANSION OF SOCIAL CONTROL OVER THE NON-DANGEROUS MENTALLY ILL IN OHIO

JESSICA L. MACKEIGAN

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I. INTRODUCTION

Timothy Halton has lived a very troubling life. Diagnosed with a mental illness at a very young age, he had frequent run-ins with the law over a variety of crimes, some petty, others violent.1 Halton has attacked family members and strangers alike,

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1 Phillip Morris, Editorial, ‘We Tried to Get Help,’ Halton’s Mother Says, PLAIN DEALER (Cleveland), May 31, 2007, at A1, available at 2007 WLNR 10242704. According to Halton’s mother, as a youth Halton killed cats and spent time in a mental institution when he was only sixteen. Id. He often ranted about killing the President and police officers. Id.; Halton Crime History, PLAIN DEALER (Cleveland), May 30, 2007, at A6, available at 2007 WLNR 10134862. Halton’s first encounter with the criminal justice system was at the age of eleven, in 1991, when he received a traffic citation. Id. Over the intervening years, he was charged with assaulting a male relative in 1999, a sixty-year-old man out for an evening stroll in 2000, and a police officer in 2003. Id. In 2001, Halton was involuntarily committed to a mental health treatment center. Id. In 2003, Halton was sentenced to four years of probation.
and his family feared for his safety, as well as their own. The courts frequently ordered Halton to receive mental health treatment and gave him probation. When he later attacked a police officer, Halton was found incompetent to stand trial and received three months of inpatient treatment. After treatment, Halton was sentenced to four years probation conditioned upon him taking psychotropic drugs. Halton’s dangerous behavior and severe mental illness made him a perfect candidate for compulsory mental health treatment under Ohio’s civil commitment laws, under which he could have received intensive therapy, medication, housing assistance, and educational and vocational training on an outpatient basis or intensive inpatient hospitalization if necessary. But instead, he spent five months in jail before a bed opened up at a mental health agency and was ultimately released from probation after only one year. The probation department had huge case loads and little time to offer the intensive care that Halton needed. During his probation, Halton had expressed to his mother his hopes of living a normal life and turning himself around. Since then, Halton had voluntarily sought treatment for his mental illness, visiting a local mental health agency for the homeless about once a month to receive antipsychotic medications, but recently had begun skipping appointments.

Tragically, on May 25, 2007, in a quiet suburban neighborhood, Halton shot and killed a young police officer, Jason West, who had responded to a call about a street

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2Halton Crime History, supra note 1.


4See id.

5Id.

6Ohio Rev. Code Ann. § 5122.01(B)(1)-(2) (West2001 & Supp. 2008) (defining the criteria for a mentally ill person subject to hospitalization by court order including posing a “substantial risk of physical harm to self or others”). Services provided by county boards of alcohol, drug addiction, and mental health services include outpatient care, inpatient hospitalization, partial hospitalization, rehabilitation, consultation, mental health education and other preventive services, emergency services, crisis intervention, mental health research, referral and information, training, substance abuse counseling, service and program evaluation, community support system, case management, and residential housing. Ohio Rev. Code Ann. § 340.09 (West, 2001 & Supp. 2008).

7Dissell, supra note 3.

8According to the supervisor of the probation unit, the county has only six probation officers which must meet weekly with some 500 mentally ill probationers, a ratio of eighty-three to one. Id. Halton’s mother suspects that he was released from probation early simply because the county could no longer afford to pay for Halton’s psychiatric treatment and his expensive medication. Morris, supra note 1.

9Morris, supra note 1.

10Harlan Spector, Suspect in Officer’s Killing Didn’t Take His Drugs, Agency Couldn’t Compel Medication for Halton, Plain Dealer (Cleveland), May 31, 2007, at A1, available at 2007 WLNR 10242703. Halton’s last visit to the offices of Mental Health Service for Homeless Persons, Inc. occurred just nineteen days prior to shooting officer West. Id.
Typical of such tragedies, the public was left wondering, Could society have prevented this from happening?\footnote{12}

In the wake of Officer West's killing and similar incidents of violence nationwide, public demand for compulsory outpatient treatment of the mentally ill has grown exponentially.\footnote{13} In response, forty-two states have enacted some form of involuntary outpatient treatment.\footnote{14} Supporters claim such laws protect the public by reducing the risk of violence among the mentally ill and providing necessary care for those that are unable or unwilling to voluntarily seek treatment.\footnote{15} However, studies show that such laws have questionable deterrent and therapeutic effects.\footnote{16} Detractors are quick to point out that these laws infringe upon the rights of the mentally ill and unnecessarily expand social control by the mental health system.\footnote{17} As the legal debate rages, researchers dispute whether mental illness is the sole cause of violence or whether deeper societal problems, such as poverty, homelessness, and drug use, are the culprits.\footnote{18}

\footnote{11}Rachel Dissell et al., Officer's Slaying Stuns Heights: Suspect Had Attacked a Policeman Before, Got Mental Treatment, PLAIN DEALER (Cleveland), May 27, 2007, at A1, available at 2007 WLNR 10016731.

\footnote{12}Spector, supra note 10.

\footnote{13}Id. (discussing Seung-Hui Cho, the mentally ill shooter of the Virginia Tech massacre, and the death of a New York woman pushed in front of a subway train by a schizophrenic man).


\footnote{15}John Petrila et al., Debating Outpatient Commitment: Controversy, Trends, and Empirical Data, 49 CRIME & DELinq. 157, 160 (2003).


\footnote{17}Jeffrey W. Swanson et al., Effects of Involuntary Outpatient Commitment on Subjective Quality of Life in Persons With Severe Mental Illness, 21 BEHAV. SCI. & L. 473, 476 (2003); DONALD M. LINHORST, EMPOWERING PEOPLE WITH SEVERE MENTAL ILLNESS: A PRACTICAL GUIDE 51 (2006); see also Jeffrey L. Geller, The Evolution of Outpatient Commitment in the USA: From Comumdrum to Quagmire, 29 INT'l J.L. & PSYCHIATRY 234, 236 (2006).

\footnote{18}R.A. Friedman, Violence and Mental Illness: How Strong is the Link?, 355 NEW ENG. J. MED. 2064, 2065-66 (2006) (discussing a link between violent behavior of the mentally ill and substance abuse, poor physical health, and homelessness); John Monahan, Mental Disorder and Violent Behavior: Perceptions and Evidence, 47 AM. PSYCHOLOGIST 511, 519 (1992) (cautioning that past psychotic symptoms "bear no direct relationship to" the current risk of violence); C.T. Sheldon et al., Social Disadvantage, Mental Illness and Predictors of Legal Involvement, 29 INT'l J.L. & PSYCHIATRY 249, 254 (2006) (discussing factors other than mental illness that lead to violence, namely drug use, poverty and homelessness); Jeffrey W. Swanson et al., The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness, 92 AM. J. PUB. HEALTH 1523, 1524 (2002) (finding an association
Ohio has become the most recent state to take up the cause with the introduction of House Bill 299—known as Jason's Law in memory of Officer Jason West—which proposes involuntary outpatient care for treatment resistant mentally ill individuals.\(^\text{19}\) Currently, the civil commitment standard in Ohio requires a finding of present dangerousness or grave disability before a person can be committed to either inpatient or outpatient care.\(^\text{20}\) Traditionally, proof of present dangerousness is "evidence of recent, overt acts and threats of violence [to self or others], instead of predictions of future dangerous behavior."\(^\text{21}\) Grave disability is often used as an alternative to present dangerousness and requires finding neglect for the person's basic needs and "an inability to live in the community safely with the assistance of others."\(^\text{22}\) Upon satisfaction of either criterion, a person is subject to court ordered treatment in the least restrictive environment, a setting that provides a patient with the greatest personal freedom while still meeting the therapeutic needs of the patient, which can range from inpatient hospitalization to outpatient care depending on the severity of illness or risk of harm.\(^\text{23}\) Jason's Law represents a major shift in the current legal structure by eliminating the necessity of proving imminent dangerousness to self or others, requiring instead that a court find that a treatment resistant person is likely to become a danger to self or others if left untreated.\(^\text{24}\) The chief goal of this legislation is to prevent relapse or violence among the mentally ill.\(^\text{25}\) This form of outpatient commitment is frequently referred to as preventative commitment or, in the case of Jason's Law, as assisted outpatient commitment.\(^\text{26}\)

Presumably, Jason's Law is aimed at preventing harm to the community that would result if a person is left untreated. At first glance, this is a noble goal, but the proposed law would cast a much wider net, provide less due process protections, and ultimately be more restrictive of the rights of non-dangerous persons than current law is for presently dangerous individuals. This result is completely irrational. Jason's Law proposes requiring the respondent to participate in the very same

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\(^{\text{22}}\)Id. at 179.


outpatient treatment mandated by current law while eliminating the need to prove imminent dangerousness, reducing the time to prepare for hearing, extending the duration of an initial court order, removing all flexibility from treatment plans, rendering treatment providers powerless to release a recovered patient from care without court approval, and threatening judicial hospitalization for those who refuse to comply.  

Jason’s Law should not be enacted as written because it will compel respondents to adhere to outpatient treatment based upon predictions of future danger to self or others rather than findings of imminent danger or incompetence, it will remove treatment flexibility currently guaranteed by Ohio law by extending the duration of treatment and limiting a treatment provider’s discretion, it will compel the use of unproven medication over the objections of a presumably competent individual without requiring a finding of incompetence, and it will further financially burden an already overburdened mental health system. Section II will discuss the origins, justification, and models of involuntary outpatient treatment laws and will outline the operation of current Ohio civil commitment law and the changes proposed by Jason’s Law. Section III will address the broader criteria of Jason’s Law in relation to current Ohio laws. Section IV will critique Jason’s Law’s interference with the doctor-patient relationship and how the proposed law will impose greater restrictions upon medical decisions than current law does. Section V will address compelled medication and the consequence for refusal to comply. Finally, Section VI will address the fiscal feasibility of Jason’s Law.

II. BACKGROUND

A. The Origins of Outpatient Commitment Laws

The earliest form of outpatient commitment originated in the early 1950s. A shift occurred from a predominant use of inpatient care to treatment in the community, which reflected a change in beliefs about the state’s role in the treatment of the mentally ill. This increased use of outpatient commitment has received mixed reviews from mental health advocacy groups.

27 Ohio H.R. 299 at 5-6.

28 In other words, while existing commitment laws provide for compelled treatment when the respondent presently or immediately poses a threat or risk of harm to self or others, as evidenced by recent overt acts or threats of violence, Jason’s Law would compel the same treatment without requiring such evidence if the respondent is mentally ill, mental illness has been a substantial factor in recent hospitalization or treatment, respondent is currently resistant to voluntary treatment, and respondent would predictably become a danger to self or others if left untreated.

29 Determinations of incompetency are “separate and distinct” from civil commitment proceedings. JOHN PARRY & ERIC Y. DROGIN, MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY: A COMPREHENSIVE REFERENCE MANUAL FOR LAWYERS, JUDGES, AND MENTAL DISABILITY PROFESSIONALS 7 (2007).


31 LINHORST, supra note 17, at 41.
In the 1950s, the introduction of new psychotrophic medications, concerns about the costs of inpatient care, and the civil rights movement were the impetus for outpatient treatment. New drugs facilitated the discharge of state mental health patients to community treatment. Outpatient treatment was viewed as a cheaper alternative to state hospitalization and as less of an infringement on patients' civil liberties. This movement became known as deinstitutionalization. Then, in the 1970s, several key federal court decisions established safeguards for the rights of the mentally ill and delineated the standards and procedures by which a person could be involuntarily committed. As a result, modern state civil commitment statutes now incorporate a dangerousness standard supported by clear and convincing evidence and procedural safeguards.

Forced treatment of mental illness is justified by the state's parens patria and police powers. According to the tenet of parens patria, the state is justified in compelling mental health treatment in the best interests of a patient if the patient is believed to be incapable of competent decision making. Alternatively, the state invokes police powers to protect public health and safety and may order a person believed to be presently dangerous into involuntary treatment to prevent violence in the community. The deinstitutionalization movement was a reflection of society's movement "from more of a medically oriented parens patria approach toward a legally oriented police power approach." Thus, the state's focus moved from comprehensive care in an inpatient setting to inclusive community based treatment, with hospitalization reserved as a last resort to be used when necessary to prevent harm to self or others.

Presently, outpatient commitment consists of three models. The first form is known as conditional release, whereby involuntary inpatients are discharged and

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32Winick, supra note 26, at 239-40; Appelbaum, supra note 30, at 18.
33Winick, supra note 26, at 239-40.
34Id.
36See Appelbaum, supra note 30, at 18; Addington v. Texas, 441 U.S. 418 (1979) (establishing the clear and convincing standard for civil commitment hearings); O'Connor v. Donaldson, 422 U.S. 563 (1975) (requiring a finding of dangerousness prior to involuntary hospitalization); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (holding that involuntary hospitalization statute must provide adequate procedural safeguards, including notice, the right to counsel, the privilege against self-incrimination, and a timely hearing).
37Linhorst, supra note 17, at 42.
38Bruce J. Winick, The Right to Refuse Mental Health Treatment 285 (Bruce D. Sales et al. eds., 1997).
39Id. at 289.
40Id. at 285.
41Linhorst, supra note 17, at 41.
42Id.
may be re-institutionalized if the conditions of their release are not met.\textsuperscript{43} The second form mandates community treatment as a less restrictive alternative to hospitalization for respondents meeting the criteria for civil commitment, but who are deemed capable of safely surviving in the community with supervision.\textsuperscript{44} Under this model, outpatient and inpatient commitment standards are the same, but treatment is less restrictive because rather than living in a large, group residence, respondents are integrated into the community and are permitted to live independently.\textsuperscript{45} The third form of outpatient commitment, preventative commitment or assisted outpatient treatment, recently arose out of concern for the ‘revolving-door’ syndrome, in which patients get caught in a cycle of impairment, inpatient treatment, conditional release, and re-hospitalization upon failure to comply with outpatient treatment.\textsuperscript{46} Under this model, mentally ill individuals who do not satisfy the traditional criteria for inpatient civil commitment—imminent danger to self or others or an inability to care for one’s basic needs—are ordered into outpatient care based upon a prediction that if the individual is left untreated, he or she will deteriorate and become dangerous to self or others.\textsuperscript{47} This type of treatment frequently consists of prescribed psychotropic medication, urine and blood tests to verify compliance with medication orders, psychotherapy, and housing assistance.\textsuperscript{48} Failure to comply with a treatment order may result in institutionalization.\textsuperscript{49} This final form of outpatient commitment is the most controversial because it restricts the rights of someone who is not imminently dangerous, but is predicted to become so if treatment is not mandated.\textsuperscript{50}

Opinions of mental health advocacy groups are split on the use and effectiveness of outpatient commitment as a preventative measure.\textsuperscript{51} Among the detractors,
Mental Health America, formerly known as the National Mental Health Association, opines in its position statement that "mandatory treatment has not been shown to add to the effectiveness of community mental health services and, indeed, may interfere with recovery by compromising personal responsibility and lowering self-esteem."52 Likewise, the Bazelon Center for Mental Health Law calls outpatient commitment a "dangerous formalization of coercion" that "deters individuals from voluntarily seeking treatment" and is a "simplistic response that cannot compensate for a lack of appropriate and effective" community services.53

Proponents, such as the National Alliance on Mental Illness and the American Psychiatric Association, counter that preventative commitment is necessary to prevent individuals from needlessly deteriorating before a court can order treatment and, if properly implemented, "can be a useful tool . . . to improve compliance, reduce re-hospitalization rates, and decrease violent behavior among [the] . . . chronically mentally ill."54 Others are more cautionary in their support due to concerns that outpatient commitment may discourage creative community solutions, may be disproportionately applied to the poor and African-Americans, and may not be sufficiently funded to address respondents' basic needs, such as housing and income assistance.55

Mandatory treatment with standard community care, the review revealed that after one year patients subjected to involuntary outpatient care were just as likely to be hospitalized for mental treatment or incarcerated as those that received non-compulsory care. Thus, demonstrating that coercion by the state had little impact upon the effectiveness of care. Id. at 9. The study concluded that a large "number of people would have to receive compulsory community treatment to gain a positive outcome." Id. at 10.

52Mental Health America, Position Statement 22: Involuntary Mental Health Treatment, http://nmhha.org/go/position-statements/22 (last visited Jan. 10, 2008). "Mental Health America believes that effective protection of human rights and the best hope for recovery from mental illness comes from access to voluntary mental health treatment and services that are comprehensive, community-based, recovery-oriented and culturally competent." Id.


55AM. ASS'N OF CMTY. PSYCHIATRISTS, POSITION PAPER: INVOLUNTARY OUTPATIENT COMMITMENT, available at http://www.comm.psych.pitt.edu/finds/ioc.html (June 2001) (last visited Jan. 10, 2008). A recent New York Times article observed that 42% of assisted outpatient treatment recipients in the state of New York were African American, while only 34% were white, despite whites comprising 62% of the state population and African Americans comprising only 16% of the state population. Michael Cooper, Racial Disproportion Seen in Applying 'Kendra's Law,' N.Y. TIMES, April 7, 2005, http://www.nytimes.com/2005/04/07/nyregion/07kendra.html (last visited Jan. 10, 2008).
With the introduction of Jason's Law and its proposal for preventative commitment, Ohio has entered this heated debate. The challenge for Ohio will be balancing the beneficial aspects of preventative commitment—reduced hospitalizations and violence—while also avoiding the criticisms so frequently lobbied at preventative commitment. This can be done by advocating voluntary compliance, increasing funding of community support systems, and adequately protecting the rights of the mentally ill.

B. Ohio's Current Civil Commitment Model

Since 1988, the first two models of outpatient commitment, conditional release and care in the least restrictive setting, have been mandated by statute in Ohio.\(^{56}\) Civil commitment in Ohio is based upon a finding of imminent danger to self or others or incapacitation to the point of inability to care for oneself.\(^{57}\) Outpatient commitment procedures in Ohio are generally flexible and responsive to the patient's ever-changing needs.\(^{58}\)

Involuntary patients can be admitted by emergency or judicial proceedings.\(^{59}\) Emergency hospitalization proceedings can be invoked against criminal offenders, probationers and parolees and can be initiated by clinicians or law enforcement agents.\(^{60}\) Judicial hospitalization proceedings can be brought against any individual and are commenced "by any person or persons with the court" filing an affidavit.\(^{61}\) The affidavit is investigated by the county mental health board, which verifies that the respondent satisfies the criteria for compelled treatment or whether alternative voluntary services are available.\(^{62}\) A probable cause hearing must be held within five days to determine whether the person does in fact satisfy the criteria for commitment.\(^{63}\)

The commitment criteria require that a person suffering from mental illness must either: (1) have threatened or attempted to inflict serious harm to self; (2) be presently dangerous to others as evidenced by recent threats or violent behavior; (3) be unable to provide for his or her own basic needs which presents "an immediate risk of serious physical impairment or injury to self" and the community cannot meet

\(^{56}\)Mark R. Munetz et al., What Happens When Effective Outpatient Civil Commitment Is Terminated?, 75 NEW DIRECTIONS FOR MENTAL HEALTH SERVS. 49, 50 (1997); OHIO REV. CODE. ANN. § 5122.15 (West 2001 & Supp. 2008) (mandating the use of the least restrictive form of therapy for a person subject to civil commitment, including mandatory outpatient care or hospitalization followed by conditional release).

\(^{57}\)OHIO REV. CODE. ANN. § 5122.01 (West 2001 & Supp. 2008).

\(^{58}\)§ 5122.15(F) (providing that a patient can be released from care when they no longer satisfy the criteria for commitment by a clinician); OHIO REV. CODE. ANN. § 5122.231 (West 2001 & Supp. 2008) (providing that a patient has the right to request additional or different services).

\(^{59}\)OHIO REV. CODE. ANN. § 5122.05 (West 2001 & Supp. 2008).

\(^{60}\)OHIO REV. CODE. ANN. § 5122.10 (West 2001 & Supp. 2008).


\(^{63}\)OHIO REV. CODE. ANN. § 5122.141(B) (West 2001 & Supp. 2008).
these needs; or (4) would benefit from treatment and need such treatment due to behavior that creates a grave and imminent risk to the substantial rights of self or others. 64 A full hearing is held within thirty days, at which time the person has the right to counsel and can cross examine witnesses and present evidence. 65 At the hearing, if the court finds that the person is subject to civil commitment, the court must order the respondent to be treated in the least restrictive environment, which can include outpatient care if adequate to treat the needs of the patient. 66 At any time during this process, a respondent can elect to voluntarily seek treatment, which results in a complete dismissal of the case. 67

An initial treatment order lasts ninety days and is renewable for up to two years. 68 If at any time the chief clinical officer determines that a patient no longer meets the involuntary commitment standard and upon giving notice to the court, the patient may be released from care or, if hospitalized, may be transferred to a less restrictive setting, such as outpatient care. 69 But a patient cannot be moved to a more restrictive setting without a motion before the court showing that the respondent presents a substantial risk of physical harm to himself or others. 70 Additionally, a patient may request supplementary or alternate services from the county mental health board at any time. 71

C. Jason’s Law: Adding Assisted Outpatient Treatment to the State’s Arsenal

Jason’s Law will expand outpatient commitment in Ohio by incorporating a preventative commitment model into existing law. 72 The law will broaden the criteria for commitment by eliminating the requirement for imminent danger to self

64 OHIO REV. CODE. ANN. § 5122.01 (West 2001 & Supp. 2008).

65 OHIO REV. CODE. ANN. § 5122.15 (West 2001 & Supp. 2008). Mental illness is defined as “a substantial disorder of thought, mood, perception, orientation, or memory that grossly impaired judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.” § 5122.01(A).

66 § 5122.15(E).

67 § 5122.15(G)(1).

68 § 5122.15(H).

69 A chief clinical officer is defined as “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 . . . . 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 the chief clinical officer’s absence.” § 5122.01(K); § 5122.15(F). Stricter standards for release and transfer exist for persons found incompetent to stand trial or not guilty by reason of insanity however this Note focuses exclusively on non-criminal patients.


72 Schopp, supra note 26, at 34.
or others and, thus, expand the number of individuals who can be committed. This law will considerably alter the landscape of civil commitment in Ohio.

A preventative commitment model will significantly change the criteria, procedures, and flexibility currently mandated by Ohio law. The proposed criteria under Jason’s Law are far less stringent and do not require a finding that a respondent is presently, immediately, or imminently dangerous to self or others or unable to make a rational treatment choice before a court can compel outpatient care. Largely based on legislation in New York known as Kendra’s Law, Jason’s Law would mandate outpatient treatment for: (1) adults; (2) suffering from mental illness; (3) who are unlikely to survive safely in the community without supervision; (4) who have a history of noncompliance with mental health treatment and whose mental illness has been a significant factor in either (i) hospitalization or receipt of related services at least twice in the past three years, or (ii) at least one act of serious violent behavior, or threats or attempts thereof, toward self or others in the last four years; (5) who are unlikely to voluntarily participate in treatment that would enable them to live safely in the community; (6) who are in need of treatment to prevent deterioration that would result in serious harm to self or others; and (7) who are likely to benefit from outpatient treatment.

The proceedings would be initiated by an adult roommate, immediate relative, current or previous mental health care provider, or probation or parole officer filing a petition with the local probate court. The petition must be accompanied by an affidavit of a mental health professional who is not the petitioner, certifying that the respondent meets all of the criteria and that they have attempted to examine or have personally examined the respondent. Before a hearing, the mental health board must draft a treatment plan and offer the respondent an opportunity to participate in


74 Id. (requiring instead that a respondent’s mental illness have been a significant factor in receiving treatment at least twice in the previous three years, excluding current care, or that the respondent has harmed or threatened to harm self or others at least once in the past four years). Therefore, under Jason’s Law it is conceivable that someone who threatened suicide more than three years prior and who is currently resistant to seeking mental health treatment can be compelled to assisted outpatient treatment regardless of the fact that there is no proof of imminent harm.

75 See Rollenhagen, supra note 19; N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2006 & Supp. 2008); Ohio H.R. 299 at 5-6.

76 Ohio H.R. 299 at 4.

77 Id. A mental health professional is defined by the proposed law as any of the following: a physician; a physician’s assistant under the direction and control of a physician; a clinical nurse specialist, certified nurse midwife, or certified nurse practitioner; a psychologist; a professional clinical counselor, or professional counselor under supervision of a psychologist, psychiatrist, professional clinical counselor, or independent social worker; an independent social worker, or a social worker under the supervision of a psychologist, psychiatrist, professional clinical counselor, independent social worker, or registered nurse with a master’s degree in psychiatric nursing; an independent marriage and family therapist, or a marriage and family therapist under the supervision of a psychologist, psychiatrist, professional clinical counselor, independent social worker, or independent marriage and family therapist. Id. at 2.
the drafting of the plan.\textsuperscript{78} A hearing must then be held within three days, at which the respondent has a right to counsel and may present evidence.\textsuperscript{79} If the court finds by clear and convincing evidence that the respondent meets the criteria for treatment and is satisfied with the proposed treatment plan, an initial six months of outpatient treatment is ordered.\textsuperscript{80} At the end of the initial treatment period, the respondent’s progress is reviewed by the court and, if the court finds that further treatment is warranted, it may order an additional period of treatment lasting up to one year.\textsuperscript{81} A treatment provider cannot substantially change a treatment plan without the consent of the respondent and the approval of the court.\textsuperscript{82} Any such change is subject to a hearing if the respondent does not consent to the change.\textsuperscript{83} If a respondent does not voluntarily comply with the treatment order, the court may order the respondent to inpatient hospitalization pursuant to existing civil commitment laws.\textsuperscript{84}

A brief comparison reveals several key changes Jason’s Law will make to Ohio’s commitment laws. First, and probably most obvious, the element of dangerousness is removed and replaced by a prediction of future harm.\textsuperscript{85} Second, the definition of a mental health professional under Jason’s Law is significantly broader, encompassing even family therapists and nurse midwives, in contrast to current law, which relies upon the recommendation of a physician and psychiatrist or clinical psychologist, and an investigation by the county’s mental services board.\textsuperscript{86} Third, Jason’s Law reduces the frequency of required reviews of the respondent’s condition and lengthens the initial treatment period from three months to six months.\textsuperscript{87} Fourth, under Jason’s Law, treatment providers must seek court approval to make any major changes to a plan, whereas current law allows providers to release from care patients that no longer meet the criteria for commitment.\textsuperscript{88} The legislature of Ohio should

\textsuperscript{78}Id. at 7.

\textsuperscript{79}Id.

\textsuperscript{80}Id. at 8.

\textsuperscript{81}Id.

\textsuperscript{82}Id. at 9.

\textsuperscript{83}Id. at 9-10.

\textsuperscript{84}Id. at 10.

\textsuperscript{85}Id. at 5; Ohio Rev. Code. Ann. § 5122.01 (West 2001 & Supp. 2008).

\textsuperscript{86}Ohio H.R. 299 at 4; Ohio Rev. Code. Ann. § 5122.11 (West 2001 & Supp. 2008) (providing that affidavit for judicial hospitalization be accompanied by accompanied by a certificate signed by either a psychiatrist or a clinical psychologist and a certificated signed by a physician stating that the person has been examined or by a separate affidavit by the applicant swearing that the respondent has refused to be examined by a psychiatrist or psychologist and a physician); Ohio Rev. Code. Ann. § 5122.13 (West 2001 & Supp. 2008) (requiring that an investigation be performed by the board of alcohol, drug addiction, and mental health services or an agency designated by the board any time an affidavit is filed).

\textsuperscript{87}Ohio Rev. Code. Ann. § 5122.21(F) (West 2001 & Supp. 2008) (requiring an examination confirming the justification for continued commitment at least every 30 days); Ohio H.R. 299.

ensure that these changes are warranted by current case law, give adequate weight to the rights of the individual, are supported by proof of effectiveness, and are adequately funded.

III. JASON’S LAW’S CRITERIA FOR ASSISTED OUTPATIENT TREATMENT

Civil commitment constitutes a significant infringement of liberty that can only be justified by a compelling state interest.89 One commentator has observed that “it is inaccurate to contend that persons subject to preventative commitment are entitled to fewer protections because the infringement on their liberty is less than hospitalization.”90 Persons subject to outpatient civil commitment, such as Jason’s Law proposes, can be told where to live, what medicines to take, and where and how often they must report for therapy.91 The U.S. Supreme Court has observed that civil commitment to a mental hospital “after a finding of probable dangerousness to self or others” can have a stigmatizing effect.92 For example, one court has held that court ordered outpatient treatment is the equivalent of commitment to a mental institution.93 Thus, preventative outpatient commitment can be just as stigmatizing as institutionalization and those persons subjected to it should be guaranteed the same protections afforded to those that are subjected to other forms of civil commitment. Therefore, it is imperative that the state have valid reasons supported by parens patria or police powers principles before imposing stigmatizing constraints upon an individual.

A state is currently permitted to compel involuntary commitment and affect a deprivation of liberty only when an individual is either presently or imminently dangerous to self or others, thus implicating the state’s police powers, or is incapable of making a competent treatment decision, thus implicating the state’s parens patria powers.94 Conversely, Jason’s Law requires neither a finding of present dangerousness nor the inability to make a competent treatment choice before

89 Addington v. Texas, 441 U.S. 418, 425 (1979); Lessard v. Schmidt, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972) (“The power of the state to deprive a person of the fundamental liberty to go unimpeded about his or her affairs must rest on a consideration that society has a compelling interest in such deprivation.”).


91 Under Jason’s Law, assisted outpatient treatment means services provided pursuant to a court order . . . that include medication; periodic blood tests or urinalysis to determine compliance with prescribed medication or the presence of alcohol or illegal drugs; individual or group therapy; educational and vocational training or activities; supervision of living arrangements; and any other services prescribed to treat a person’s mental illness.

Ohio H.R. 299 at 1.

92 Addington, 441 U.S. at 425.

93 United States v. B.H., 466 F. Supp. 2d 1139, 1149 (N.D. Iowa 2006). In B.H., the Northern District of Iowa held that a respondent ordered to outpatient treatment was “committed to a mental institution,” and thus was barred by federal statute from owning firearms. Id.

94 Id.
subjecting a person to potentially stigmatizing treatment. Instead, its criteria is based on speculative risk assessments and does not require actual proof of imminent danger; thus, a mentally ill person can be subject to an outpatient treatment order simply for seeking treatment in the past and currently resisting treatment. A patient may choose to forego treatment for many complex reasons; it simply should not be supposed that such a decision is based on incompetence or an inability to make treatment decisions.

According to the Supreme Court of Ohio, “[O]nly when a court finds that a person is incompetent to make informed treatment decisions do we permit the state to act in a paternalistic manner, making treatment decisions in the best interest of the patient.” The criteria under Jason’s Law, however, would have the effect of requiring non-dangerous, competent persons to comply with court mandated treatment. This could occur if a treatment resistant person, having previously sought voluntary treatment and having stopped such treatment for personal reasons, but not having committed any violent acts or threats to self or others, is ordered to accept treatment on the basis of a prediction of future risk. This effect has been documented in New York where Kendra’s Law requires substantially the same criteria. Such criteria cannot be justified by the state’s parens patria interests.

95See discussion supra note 69 and text of Section III.

96“The Supreme Court has stated, albeit in dicta, that ‘many psychiatric predictions of dangerousness are inaccurate.’ Yet, such predictions are offered—frequently in minimalist ways that are subject to no meaningful cross-examination or challenge—daily in civil commitment courts across the country,” Michael L. Perlin, “Half-Wrecked Prejudice Leaped Forth”: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did, 10 J. CONTEMP. LEGAL ISSUES 3, 21-22 (1999) (quoting Riggins v. Nevada., 504 U.S. 127, 133-34 (1992)).

97Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 20 (Ohio 2000) (“[M]ental illness and incompetence are not one and the same.”). A decision to not comply may be more indicative of an aversion to medication side effects, than to a lack of competence or an inability to make an informed treatment decision. Michael L. Perlin, Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra’s Law as Case Study, 9 PSYCHOL. PUB. POL’Y & L. 183, 197 (2003).

98Perlin, supra note 97, at 188.

99The criteria for Jason’s Law require an either/or finding of recent hospitalization or similar treatment for a mental illness (twice in the past 48 months) or recent acts or threats of violence (once in the last 36 months). H.R. 299, 127th Gen. Assem., Reg. Sess., at 5-6 (Ohio 2007). Conceivably, persons who have never acted violently can be committed to outpatient treatment based simply on prior treatment, voluntary or not, and a prediction that they will become violent if left untreated.

100Id.

101According to the organization New York Lawyers For The Public Interest, Kendra’s Law “is used primarily against people who have had more than one psychiatric hospitalization but no history of hurting others.” New York Lawyers For The Public Interest, Implementation of “Kendra’s Law” is Severely Biased, at 3, available at http://nylpi.org/pub/Kendras_Law_04-07-05.pdf. A study conducted by the state of New York confirms this, finding that eighty-five percent of the more than 10,000 respondents subject to assisted outpatient treatment orders between the years 1999 and 2004 had not caused physical harm to another person during the four year period preceding their commitment. Id.
But New York courts have upheld the validity of similar criteria, despite the absence of an incapacity provision, because court ordered medication is not forcibly administered. Critics contend, however, that coercion in the form of threatened hospitalization, the consequence for noncompliance with a treatment plan, is akin to forcibly medicating someone. It is difficult to see a meaningful difference between forcibly administering a medication to someone and using a court order to compel self-administration. In either instance, the state has removed the respondent’s ability to make a voluntary choice and, in the latter instance, it will have done so without first finding the respondent incompetent to make such a choice.

Other states with statutes similar to Jason’s Law require a court to find that the respondent is unable to make a treatment choice before involuntary outpatient treatment can be ordered. These statutes are more in keeping with the principle of

102 Schopp, supra note 26, at 36.


104 O’Connor, supra note 103, at 347; see also LINHORST, supra note 17, at 47-48, 57. Studies are conflicted as to whether coercion improves functioning of the severely mentally ill or discourages voluntary participation in treatment. Marvin S. Swartz, et al., Does Coercion Keep People Away from Mental Health Treatment?: Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals, 21 BEHAV. SCI. & L. 459, 462 (2003). One study conducted in California found that forty-seven percent of respondents “avoided traditional mental health services for fear of being involuntarily committed.” Id. Still another study, found no “chilling effect of involuntary outpatient commitment on voluntary help-seeking,” suggesting that such an effect is more likely linked to inpatient commitment. Id. at 471.

105 States that require some form of diminished capacity to make a rational or informed treatment decision before outpatient treatment can be compelled include Alabama, Arizona, Arkansas, Georgia, Hawaii, Idaho, Iowa, Kansas, Michigan, Minnesota, Missouri, North Carolina, New Hampshire, North Dakota, South Carolina, Texas, Utah, and Wisconsin. ALA. CODE § 22-52-10.2 (LexisNexis 2006) (“the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable”); ARIZ. REV. STAT. ANN. § 36-501(33)(b) (2003 & Supp. 2006) (“substantially impairs the person’s capacity to make an informed decision regarding treatment”); Ark. Code Ann. § 20-47-207(c) (2002) (“the person’s understanding of the need for treatment is impaired to the point that he or she is unlikely to participate in treatment voluntarily”); Ga. Code Ann. § 37-3-1 (West, Westlaw through 2007 Reg. Sess.) (“unable voluntarily to seek or comply with outpatient treatment”); HAW. REV. STAT. § 334-121 (LexisNexis 2004) (“the person’s current mental status or the nature of the person’s disorder limits or negates the person’s ability to make an informed decision to voluntarily seek or comply with recommended treatment”); Idaho Code Ann. § 66-339A (repealed 2008) (“the person lacks capacity to make an informed decision concerning his need for treatment”); Iowa Code Ann. § 229.1(16) (West 2006 & Supp. 2007) (“lacks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment”); Kan. Stat. Ann. § 59-2946(f) (2005) (“lacks capacity to make an informed decision concerning treatment”); Mich. Comp. Laws Ann. § 330.1401 (West 1999 & Supp. 2008) (“judgment is so impaired that he or she is unable to understand his or her need for treatment”); Minn. Stat. Ann. § 253B.065(5) (West 2007) (“the proposed patient, when competent, would have chosen substantially similar treatment under the same circumstances”); Mo. Ann. Stat. § 632.005(9) (West 2006) (“an impairment in his capacity
parens patria, allowing a state to substitute its judgment only when the respondent is unable to make a treatment decision. For example, Hawaii's criteria for assisted outpatient commitment requires that the respondent's "disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment." 106 Hawaii's outpatient commitment law goes even further in protecting the rights of the individual by specifically forbidding physical restraint and forcible medication and providing that a refusal to accept treatment may not be used as evidence against the respondent in a proceeding for involuntary hospitalization. 107

The one exception to the incompetence rule is when the state's police power is applicable. The U.S. Supreme Court has held that absent present dangerousness, a finding of mental illness alone does not justify state compelled treatment. 108 Rather, the state's police power is implicated only when a respondent presents "an imminent threat of harm" to self or others. 109 One of the sponsors of Jason's Law contends that the law will only apply to "[a] small segment of folks . . . who are prone to become violent" when left un-medicated. 110 But the Ohio Supreme Court has held that, "[t]he police power may not be asserted broadly to justify keeping patients on antipsychotic drugs to keep them docile, thereby avoiding potential violence." 111 Furthermore, the

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108 See O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("[T]here is no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom . . . . [T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution . . . . Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.") (emphasis added). Likewise, fear of potential violence as opposed to present dangerousness should not be used to justify compelling a competent person to seek outpatient treatment, thus depriving him or her of medical liberty.


111 Steele, 736 N.E.2d at 18 (emphasis added).
court applies a totality of circumstances test to determine whether a person should be subjected to court ordered treatment and considers such factors as “whether...the individual currently represents a substantial risk of physical harm to himself or other members of society” and any “past history [which demonstrates] the individual's degree of conformity to the laws, rules, regulations and values of society.”

The evidence required includes the opinion of the treating physician and concrete facts that demonstrate that the respondent is in need of compulsory treatment.

As written, the proposed law is overbroad, ambiguous, and does not specifically identify “the features and dimensions that distinguish [the mentally disordered] who act violently from the majority who do not.” Instead, outpatient civil commitment under Jason’s Law would be based on a prediction that a person is unlikely to survive safely in the community without treatment and would likely harm themselves or others if left untreated. Such predictions should not be based on generalized assumptions that the mentally ill behave more violently than the general public.

According to several recent studies, the majority of mentally disordered individuals are not prone to violence. It has been proven that other risk factors are much more significant predictors of future violence than mental illness alone. For instance, one study found that drug abuse and “specific clinical risk factors” present within a minority of the mentally ill, such as “paranoid, narcissistic, and passive-aggressive personality disorders,” have a higher correlation with violence than general diagnoses of mental illness. However, one researcher has cautioned that, until clinicians can accurately identify these risk factors, lowering the threshold for civil commitment—by eliminating the imminent danger requirement—is unwarranted.

The justification for Jason’s Law, either under the police or parens patria powers, is tenuous at best. The goal of preventing violence is valid, but merely “relating to persons as if they represent a violence threat simply because of their

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113 In re Miller, 585 N.E.2d 396, 402 (Ohio 1992).
116 Substance Abuse & Mental Health Services Administration: Understanding Mental Illness, Violence and Mental Illness: The Facts, http://www.samhsa.gov/MentalHealth/understandingMentalIllness_Factsheet.aspx; Monahan, supra note 18, at 519 (“By all indications, the great majority of people who are currently disordered—approximately 90%...—are not violent.”); Friedman, supra note 18, at 2065 (“Because serious mental illness is quite rare, it actually contributes very little to the overall rate of violence in the general population; the attributable risk has been estimated to be 3 to 5%.”).
117 Nestor, supra note 114, at 1973-74.
118 See id. According to Nestor, rates of violence among substance abusers are twelve to sixteen times higher than the average person compared to only five times higher for those suffering from mental illness. Id. at 1974.
119 Friedman, supra note 18, at 2066.
history of illness or hospitalization represents a grave personal injustice.\textsuperscript{120} Should it become law, courts interpreting Jason’s Law must be careful to guard against reliance on “general statement[s] of what a patient with [a particular] disorder could experience” as proof of a substantial risk of harm to self or others.\textsuperscript{121} Due consideration must also be given to the circumstances surrounding any incidence of violence or threats of violence, such as at whom the act was directed and whether a sufficient explanation existed for the behavior.\textsuperscript{122}

Both Jason’s Law and current Ohio law can compel outpatient treatment; however, Jason’s Law proposes to restrict a patient’s liberty under far less stringent criteria than are currently supported by relevant case law.\textsuperscript{123} At a minimum, predictions of violence should be based on the individual’s immediate past history of violence or threats of violence rather than extending this period back four years. Moreover, such predictions must not be based on generalized data about a particular mental illness, but should be based upon individualized risk factors. In order to address these pitfalls, the text of Jason’s Law must require the state to prove that the respondent has previously sought treatment \textit{and} has either recently threatened or acted violently toward self or others or is presently suffering from a substance abuse problem, thus justifying the statute under the police power.\textsuperscript{124} Alternatively, Jason’s Law could require a finding that the respondent is unable to make an informed treatment decision. Other states’ outpatient commitment statutes require that a person be unable to make a rational treatment choice before treatment can be compelled.\textsuperscript{125} In effect, such a finding could substitute for the lack of a dangerousness standard in Jason’s Law and would constitute a \textit{pares patria} justification. Either outcome would be more supportable under case precedent than the standard as currently written.

IV. THE INFLEXIBILITY OF TREATMENT PLANS UNDER JASON’S LAW

The right to determine the course of one’s health treatment is constitutionally protected and, according to the Supreme Court of Ohio, is a fundamental and natural

\textsuperscript{120} Bruce G. Link & Ann Stueve, \textit{Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls}, in \textit{Violence & Mental Disorder} 137, 156 (John Monahan & Henry J. Steadman eds., 1994).

\textsuperscript{121} \textit{In re I.K.}, 663 N.W.2d 197, 203 (N.D. 2003) (holding that testimony to establish proof of a substantial risk of harm must be based on evidence specific to the individual and not based upon generalized statements of typical risks associated with any one particular disorder).

\textsuperscript{122} \textit{See In re} Mental Illness of Thomas, 671 N.E.2d 616, 621 (Ohio Ct. App. 1996) (finding a single homicidal threat made six months prior to the filing of a petition for involuntary hospitalization insufficient to establish proof of imminent danger when threat was directed at estranged husband during the course of a heated argument).

\textsuperscript{123} \textit{See} Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 10 (Ohio 2000).

\textsuperscript{124} Thus, criterion three would require that a patient have been hospitalized or treated for their mental illness at least twice in the last four years, \textit{and} have engaged in one or more acts or threats of violence in the last three years.

\textsuperscript{125} \textit{See} discussion, \textit{supra} note 105.
right. Inherent in this right is the liberty to refuse medical treatment, particularly unwanted medications. Accordingly, treatment decisions, particularly those regarding medication, are regarded as the province of the doctor-patient relationship and should be given great deference by the courts. Current Ohio civil commitment law is mindful of a patient’s medical liberties by ensuring that patients participate in the drafting of treatment plans and requiring that such participation is documented, by requiring that patients are given notice of the right to refuse unnecessary or excessive medication, and by keeping treatment plans flexible to meet the changing needs of the patient.

The passage of Jason’s Law would place greater restrictions on the medical liberties of the potentially dangerous individual than current law places on the presently dangerous individual. This result is irrational. If the criteria for outpatient commitment are to be broadened to include even those respondents who are not presently dangerous, then treatment flexibility should remain at current levels or be broader itself. It makes no sense to give non-dangerous individuals less influence over the course of their treatment than current law permits the imminently dangerous. Thus, Jason’s Law must give more control to the treating physician with proper consideration for the patient’s ability to competently choose the course of treatment.

Ohio civil commitment law requires documentation that patients have actively participated in drafting treatment plans and that these plans set reasonable objectives and goals for the respondent. Jason’s Law, in contrast, does not require any documented proof that a respondent has participated in the drafting of the plan. Instead, all that is required is that the respondent be given an opportunity to participate. The county board of mental health would be required to draft a plan

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126 Cruzan v. Dir. Mo. Dep’t of Health, 497 U.S. 261, 278 (1990); Steele, 736 N.E.2d at 15 (“The right to refuse medical treatment is a fundamental right in our country, where personal security, bodily integrity, and autonomy are cherished liberties. These liberties are not created by statute or case law . . . . Our belief in the principle that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body’ . . . is reflected in our decisions.”) (citing Schloendoff v. Soc. of New York Hosp., 103 N.E. 92, 93 (N.Y. 1914)); Nickell v. Gonzalez, 477 N.E.2d 1145 (Ohio 1985).


128 Steele, 736 N.E.2d at 18; In re Burton, 464 N.E.2d 530, 536 (Ohio 1984).

129 OHIO REV. CODE. ANN. § 5122.01(V) (West, Westlaw through 2007 File 32 of the 127th GA) (“The active participation of the patient in establishing the objectives and goals shall be documented”); See OHIO REV. CODE. ANN. § 5122.27(D)(6) (West 2006 & Supp. 2008) (“the right to be free from unnecessary or excessive medication”); § 5122.27(D) (requiring “periodic reevaluations of the treatment plan by the professional staff at intervals not to exceed ninety days”).

130 This result occurs because Jason’s Law does not permit a clinician to substantially change a plan without court approval or release a patient once they no longer satisfy the criteria as provided by current Ohio commitment law. H.R. 299, 127th Gen. Assem., Reg. Sess., at 7 (Ohio 2007).

131 § 5122.01(V).

132 Ohio H.R. 299 at 7.
within two days of receipt of court notice.\textsuperscript{133} Two days is very little time to draft a meaningful plan that includes individualized goals or objectives, or to ensure participation by the respondent in its drafting.\textsuperscript{134} Such a small window of opportunity does not take into account the possibilities that a respondent may be homeless and, thus, lacking access to reliable transportation or traditional modes of communication. The result could be that a patient has had no input into the drafting of his or her own treatment plan. This result would be particularly unreasonable if the plan required the participant to take medications with potentially dangerous side effects.

Jason’s Law would further restrict the respondent’s medical liberties by limiting the treatment provider’s ability to change a treatment plan. Under current law, a chief clinical officer is only required to file a motion with the court if application of more restrictive treatment is desired, such as movement from an outpatient setting to hospitalization.\textsuperscript{135} A hearing will be held only if the patient objects to the change.\textsuperscript{136} Any change to less restrictive treatment requires only that notice be given to the court; it does not require a hearing.\textsuperscript{137} Upon receiving notice of the change, the court can confirm the change or dismiss the case entirely.\textsuperscript{138} For instance, if a respondent reacts poorly to medication and talk therapy would be just as effective at accomplishing the treatment goals, then a provider can proceed with the least restrictive treatment. Additionally, the standards of care under Ohio law require that all committed patients “receive periodic reevaluations of the [court ordered] treatment plan by the professional staff” at least once every ninety days.\textsuperscript{139}

In contrast, Jason’s Law requires that a treatment provider first petition the court before making any substantive change to a treatment plan, defined as “any addition, deletion, or amendment . . . that would affect the mental health of the assisted outpatient,” and requires that the court give notice of the petition to change the plan to the original petitioner and any adult living with the respondent.\textsuperscript{140} The court may approve the change as long as the patient does not object, but if any of the notified parties objects, then a hearing must be held within five business days.\textsuperscript{141} The absurd result is that patients could be compelled to adhere to medication orders despite unwanted side effects or else face judicial hospitalization while awaiting the court’s approval of the doctor’s treatment recommendations. Even more illogically, the

\begin{footnotesize}
\textsuperscript{133} \textit{Id.}

\textsuperscript{134} Perlin, supra note 99, at 197 (2003). As Perlin points out, persons not already in the care of the state or a physician are more difficult to locate. \textit{Id.}

\textsuperscript{135} \textbf{OHIO REV. CODE. ANN.} § 5122.20 (West 2001 & Supp. 2008).

\textsuperscript{136} \textit{Id.}

\textsuperscript{137} \textbf{OHIO REV. CODE. ANN.} § 5122.15(F) (West 2001 & Supp. 2008). Again, the procedures differ for those that have been referred for involuntary services pursuant to a criminal charge, and are either incompetent to stand trial or not guilty by reason of insanity.

\textsuperscript{138} \textit{Id.}

\textsuperscript{139} \textbf{OHIO REV. CODE. ANN.} § 5122.27(D) (West 2001 & Supp. 2008).


\textsuperscript{141} \textit{Id.}
\end{footnotesize}
proposed law would allow third parties to overrule medical decisions made by trained providers. Once again, the proposed law is more restrictive of a patient’s rights than current law, despite the fact that the patient is not presently dangerous or incompetent.

Lastly, present law allows a chief medical officer to immediately release a patient from involuntary treatment if, at any time, the patient no longer meets the criteria for civil commitment. The law provides for an initial treatment order of ninety days, with an examination required every thirty days to confirm that continued commitment is necessary. Unreasonably, Jason’s Law would not compel the same frequency of review despite being based on even more lenient criteria, mandating instead that the respondent be treated for an initial period of up to six months, with the first review occurring at the end of that period. Further, at the end of the initial treatment period, the plan can be renewed for a period up to one year, without another review until the end of that year. The only presumable relief would be for the patient to file an appeal, which conceivably could take longer to litigate than the six month treatment period. In effect, imminently dangerous respondents are provided with greater procedural reviews under current law than Jason’s Law would grant to those who are merely predicted to become dangerous.

To reconcile these conflicts with present law, Jason’s Law should be amended to grant, at the very least, the same protections offered under current law. First, the law should require documented proof that the respondent has participated in drafting the treatment plan. This may be achieved by requiring a continuance of the hearing if the court finds that the respondent has not participated in the treatment planning due to time constraints or inadequate notice. Second, providers should be able to change treatment plans to fit the needs of the patient without cumbersome procedural hurdles. Thus, a hearing should be required only if the respondent objects to the change, not if third parties outside of the doctor-patient relationship do not approve. Additionally, the bill should be amended to grant respondents the ability to petition for reasonable amendment or termination of their treatment plans. Finally,

142 Ohio Rev. Code. Ann. § 5122.21(B) (West 2001 & Supp. 2008) ("After a finding . . . that a person is a mentally ill person subject to hospitalization by court order, the chief clinical officer or the hospital or agency to which the person is ordered . . . may . . . grant a discharge without the consent or authorization of any court."); Ohio Rev. Code. Ann. § 5122.19 (West 2001 & Supp. 2008) (requiring an examination of every person subject to involuntary commitment within twenty-four hours of admission, to a hospital or community mental health agency, certifying that the person meets the criteria for civil commitment, and requiring immediate release if the person does not meet the criteria).

143 Ohio Rev. Code. Ann. § 5122.15(C) (West 2001 & Supp. 2008) (limiting an initial treatment order to ninety days); § 5122.21(A) (requiring an examination confirming the justification for continued commitment at least every thirty days).

144 Ohio H.R. 299 at 8.

145 Id.

medical judgment and competent treatment choices should be given greater
decence; thus, a provider’s ability to discharge under current law should be retained
and the frequency of review should mirror current state law—at least every ninety
days.

V. COMPELLED MEDICATION AND THE CONSEQUENCES OF REFUSAL

A reasonable inference can be drawn that Jason’s Law would be focused on
compelling medication. The statutory definition of assisted outpatient treatment
evidences this intent by defining such treatment first and foremost as “services
provided pursuant to a court order that include medication [and] periodic blood tests
or urinalysis to determine compliance with prescribed medication.”147 Data from the
state of New York, where Kendra’s Law largely parallels the proposed Jason’s Law,
indicates that eighty-eight percent of respondents subjected to assisted outpatient
treatment orders there are required to take medication.148 Additionally, the chief
sponsor of Jason’s Law has stated that a respondent who is “supposed to be on
medication [that] elects not to take them” endangers self and others.149 But under
Ohio law, the civilly committed retain the right to be free from unnecessary or
excessive medication and may only be forcibly medicated pursuant to a finding of
imminent danger or incompetence.150 Jason’s Law guarantees no such right. Instead,
it threatens respondents with hospitalization for noncompliance with medication
orders.151

Jason’s Law proposes compelling medication in the interest of protecting society
or the individual from potential harm.152 New York courts interpreting Kendra’s
Law have thus far held that this is a substantial enough interest to justify ordering
the respondent to take medications.153 These courts draw a distinction between physical,
forcible medication and court compelled self-medication.154 Force is defined as
“power, violence, or pressure directed against a person or thing” or as “[compelling]
by physical means or by legal requirement.”155 Force is “not necessarily confined to

147Ohio H.R. 299 at 1.


149Rollenhagen, supra note 19. The title of Rollenhagen’s article alone (Statehouse Bill Could Force Drugs on Mentally Ill) is indicative of the demand for forced medication. See also Spector, supra note 10; Editorial, Jason’s Law Requiring Mentally Ill People to Take Their Medications Would Be a Benefit to All Ohioans, Not an Unfair Imposition, PLAIN DEALER (Cleveland), June 3, 2007, available at 2007 WLNR 10437106.


151H.R. 299, at 7.

152A prediction of danger under Jason’s Law does not statutorily require proof of current
or prior violent behavior. Id.


154In re K.L., 806 N.E.2d at 486.

a physical manifestation; there may be an exertion of force through the practice of a deceit.”\textsuperscript{156} Under Jason’s Law, respondents will be led to believe that they will be hospitalized based simply on a refusal to comply with medication orders, while in reality the higher standards of imminent danger to self or others or incompetence would still need to be proven prior to involuntary hospitalization.\textsuperscript{157} Thus, the distinction between forcible medication and court ordered medication is unfounded because most patients will feel \textit{forced} to comply with a court order to take compelled medication rather than risk being hospitalized for noncompliance.\textsuperscript{158}

Research has demonstrated that psychotropic medications pose dangerous, even fatal risks to a patient, while conferring only a minimal benefit.\textsuperscript{159} The risks of psychiatric medications are well documented and can include severe, and sometimes irreversible, neurological disorders and, in rare instances, even death.\textsuperscript{160} Moreover, a considerable minority of the mentally ill do not benefit at all from medication, and any benefits that are conferred are short in duration.\textsuperscript{161} One recent study revealed that two of the most commonly prescribed antipsychotic medications, Risperdal and Haldol, used to reduce aggression in the mentally disabled, were found to be no more effective than a placebo, leading the researchers to conclude that this type of treatment “should no longer be regarded as a satisfactory form of care.”\textsuperscript{162} Other research has shown that “long-term drug treatment may impair memory, reasoning ability, mental speed, learning capacity, and efficiency of mental functioning in general.”\textsuperscript{163} In addition to having lasting effects on the brain, another of the more commonly used drugs, Zyprexa, was recently revealed to be a substantial factor leading to significant weight gain and diabetes.\textsuperscript{164} Due to the numerous side effects,

\textsuperscript{156} \textit{Ballentine’s Law Dictionary} 485 (3d ed. 1969).

\textsuperscript{157} One commentator observed that “[p]reventative commitment then operates as a kind of judicial intimidation, which can only work if the respondent mistakenly assumes that the judge’s order must be obeyed” to avoid inpatient treatment. Stefan, \textit{supra} note 90, at 294-95.

\textsuperscript{158} See Stefan, \textit{supra} note 90, at 294-95.

\textsuperscript{159} \textit{Winick, supra} note 38, at 70-76.


\textsuperscript{161} \textit{Winick, supra} note 38, at 75; Gelman, \textit{supra} note 160, at 533-35.

\textsuperscript{162} Benedict Carey, \textit{Drugs Offer No Benefit in Curbing Aggression, Study Finds}, \textit{N.Y. Times}, at A11 (“The new study tracked 86 adults with low I.Q.’s in community housing in England, Wales and Australia over more than a month of treatment. It found a 79 percent reduction in aggressive behavior among those taking dummy pills, compared with a reduction of 65 percent or less in those taking antipsychotic drugs.”).

\textsuperscript{163} \textit{Winick, supra} note 38, at 75.

\textsuperscript{164} Alex Berenson, \textit{Lilly Adds Strong Warning Label to Zyprexa, a Schizophrenia Drug}, \textit{N.Y. Times}, Oct. 6, 2007, at C3 (discussing the apparent twelve year cover-up by drug maker Eli Lilly of the detrimental physical effects of Zyprexa, one of the most commonly prescribed drugs for schizophrenia or bipolar disorder). “One in six patients who take Zyprexa will gain more than thirty-three pounds after two years of use.” \textit{Id.}
"[w]hether the potential benefits [of medication] are worth the risks is a personal
decision that, in the absence of a compelling state interest, should be free from
government intrusion."\textsuperscript{165}

In light of the risks and minimal benefits of medication, the patient's and
physician's views should be given the greatest deference, unless the patient lacks the
competency to make a rational treatment choice or poses an imminent danger to self
or others.\textsuperscript{166} These are the rights currently guaranteed under Ohio law; it makes no
sense to limit these rights just because the patient is not being physically restrained
when medication is administered. Jason's Law should require that respondents be
fully advised of their right to refuse medication and when this right can be
 overridden. Rather than using coercive threats, the state should seek to form a
cooperative relationship with patients, giving full respect for their wishes, until such
time as they are no longer able to make rational choices or become an imminent
danger to self or others.

The use of advanced directives could be a way of fostering cooperation and
respect for involuntary patients. An advanced directive is a written instrument
drafted during a period of competency in which an individual expresses how future
health care needs should be addressed during a period of incompetency.\textsuperscript{167} Just as in
right to die cases, such an instrument would prevail over the state's \textit{pares patria}
interests in compelling treatment.\textsuperscript{168} However, should an individual not only become
incompetent but dangerous as well, the state's police power would override any
previously expressed desires of the patient.\textsuperscript{169} In this respect, the state's ultimate
purpose of promoting public health and safety would not be frustrated by the use of
such a document.

If Jason's Law is to be enacted in Ohio, the state must make certain that
respondents truly understand their rights to refuse medication.\textsuperscript{170} Because
psychotropic medications have the potential for serious side effects and may not
even be effective at preventing violence, the state must not focus too heavily on
medication alone. Therefore, an effort should be made early in any commitment
process to secure advanced directives from competent patients so that their wishes
can be respected should they become incompetent. The courts and treatment
providers must be encouraged to use the full range of services mandated by the
proposed law, including housing assistance, job training, and therapy, to encourage
empowerment of the mentally ill rather than simply resorting to coerced medication.

\textsuperscript{165}Steele v. Hamilton County Cmty. Mental Health Bd., 736 N.E.2d 10, 17 (Ohio 2000).

\textsuperscript{166}Winick makes reference to quarantine and epidemics where compulsory treatment or
vaccination is justified by public health concerns. \textit{Winick}, supra note 38, at 394 (citing Jacobson v. Massachusetts, 197 U.S. 11 (1905) (holding that the state's police power interest in preventing small pox epidemic outweighed a competent individuals right to refuse vaccination)).

\textsuperscript{167}\textit{Winick}, supra note 38, at 392.

\textsuperscript{168}ld. at 392.

\textsuperscript{169}ld.

VI. OHIO'S LACK OF SUFFICIENT FUNDING TO SUPPORT JASON'S LAW

As with any public health measure, the Ohio legislature must give due consideration to the availability of funds and services necessary to implement Jason's Law. The effectiveness and proper application of involuntary outpatient commitment depends upon there being adequate resources and facilities to ensure the "highest quality mental health care." These concerns are particularly relevant in light of a report released in 2004 by the Ohio Department of Mental Health (ODMH) detailing the 'crisis' facing Ohio's acute mental health care delivery system. According to the report, Ohio's mental health system has been plagued by insufficient funding and a limited availability of services while simultaneously experiencing an increase in demand. Against this backdrop, the Ohio legislature must ask whether implementation of Jason's Law is realistically feasible.

Ohio's spending on mental health care has steadily declined since 1997, from roughly $325 million to $225 million. As overall funding has decreased, the state has increasingly shifted the majority of its mental health care dollars from inpatient care to community care, slashing the number of public hospital inpatient beds by twenty-one percent between 1997 and 2002 from 1444 to a measly 1146 statewide. These budgetary cuts, coupled with growing demand, have left the state unable to properly address the needs of the mentally ill, leading ODMH to observe that "[t]he decline in state funding has eroded the community's capacity to provide quality care.'

This "erosion" is characterized by long waiting periods for care, overburdened providers, and insufficient staffing to meet public demand. According to a 1999 report by the Surgeon General, lack of services is an organizational barrier which

171See, e.g., AM. ASS'N CMTY. PSYCHIATRISTS, supra note 55; AM. PSYCHIATRIC ASS'N, MANDATORY OUTPATIENT TREATMENT RESOURCE DOCUMENT 11-12 (1999), available at www.psych.org/edu/other_res/lib_archives/archives/199907.pdf ("[T]he history of de-institutionalization has not provided reassurance that these resources will be forthcoming."). A study of eight states with some form of involuntary outpatient commitment found several implementation problems, including inconsistent application from county to county, difficulty monitoring treatment, a shortage of means to take non compliant respondents to hospital for reexamination, and limited availability of treatment services. Petralia, supra note 15, at 167-68.


173Id.

174Id. at 11.

175Id. at 5. Amongst private hospitals, the availability of beds is just as limited, with the number of beds decreasing during the same time period by thirteen percent from 3456 beds to 2842 beds. Id.

176Id. at 11. See also id. at 19. Thus far, private insurance companies have not stepped up to fill the void as evidenced by their increasing refusal to reimburse for psychiatric care and subsequent closures of inpatient facilities. Id. at 12.

177Id. at 16-17.
deters individuals from seeking help.\textsuperscript{178} In Ohio, patients must wait from forty-five to ninety days for outpatient services.\textsuperscript{179} And in Cuyahoga County, which has the highest rate of mental illness in Ohio and is where Timothy Halton was from, roughly 500 mental health and retardation cases are assigned to meet weekly with a mere six probation officers.\textsuperscript{180} Officials there have already debated the value of having a preventative outpatient commitment program, but concluded that the county mental health board simply could not afford such a program.\textsuperscript{181} The difficulties facing urban counties, such as Cuyahoga, are magnified in rural counties, where the ratio of psychiatrists or psychiatric nurses to the general population ranges from zero to one for every 20,000 residents.\textsuperscript{182}

All of these deficiencies become even more compelling when one looks at the statewide growth in demand for mental health services. Demand for “outpatient crisis intervention services” in Ohio swelled by a whopping sixty-two percent in three short years between 2000 and 2003, from 29,000 persons requesting care to 46,500.\textsuperscript{183} The growth in demand can also be attributed to growth of the Medicaid state, with ODMH observing that the large amount of Medicaid eligible consumers has caused providers to deny access to non-Medicaid eligible consumers shifting the demand to the criminal justice system, family, and emergency departments.\textsuperscript{184} Should Jason’s Law be enacted, it can be rationally predicted that these numbers will swell even more with the courts having to sift through those that meet the proposed criteria for outpatient commitment and those who do not. This will inevitably use

\begin{itemize}
\item \textsuperscript{179}OHIO DEP’T OF MENTAL HEALTH, supra note 172, at 16. “Over half of Ohio mental health boards report that consumers can wait up to 45 working days to access outpatient psychiatric services. An additional nine boards reported consumers must wait up to 60 working days for services, while eight boards reported wait times of up to 90 days or more.” Id.  
\item \textsuperscript{180}Harlan Spector, Halton Brings Attention to Mandatory Treatment, PLAIN DEALER (Cleveland), July 14, 2007, at A1 (citing a study finding Cuyahoga County to have the highest rate of mental illness in Ohio); Dissell, et al., supra note 3 (discussing the lack of funding and frustration felt by criminal justice officials charged with supervising the mentally ill).  
\item \textsuperscript{181}Spector, supra note 180. The county mental health board budget last year was $118 million. Id. Yet, in 2004, the county mental health board asked for a mere $250,000 to fund a pilot program to create “a team to monitor 30 ‘frequent fliers’—severely mentally ill individuals with histories of relapse and repeat hospitalizations,” but the proposal and another one like it proposed recently were both scrapped due to a lack of funding. Id.  
\item \textsuperscript{182}OHIO DEP’T OF MENTAL HEALTH, supra note 172, at 14. The shortage of mental health professionals in rural areas was recently documented by the President’s New Freedom Commission on Mental Health, which found that greater than eighty-five percent of the areas designated as mental health professional shortage areas by the federal government were rural. NEW FREEDOM COMM’N ON MENTAL HEALTH, SUBCOMM. ON RURAL ISSUES: BACKGROUND PAPER, DEP’T OF HEALTH AND HUMAN SERVS., Pub. No. SMA-04-3890, at 11 (2004), available at http://www.mentalhealthcommission.gov/papers/Rural.pdf.  
\item \textsuperscript{183}OHIO DEP’T OF MENTAL HEALTH, supra note 172, at 19.  
\item \textsuperscript{184}Id. at 11-12.
\end{itemize}
more resources and energy than the system can currently support. For example, in New York where Kendra’s Law was enacted in 2000, one observer noted that during its initial four years of application only about one out of every four of the more than 7,000 petitions investigated resulted in an order for assisted outpatient treatment, leading the author to conclude that Kendra’s Law was a waste of “expensive investigative and judicial resources.”

At this time, Ohio simply does not have the resources to spare such a large undertaking as Jason’s Law proposes without substantial increases in funding; yet, Jason’s Law carries with it no appropriation for separate funds. If the state is to compel persons to treatment, it should at a minimum be able to deliver on its promise of treatment. The new model would require every county’s participation, yet rural counties forced to comply with the state mandate will be ill equipped to deal with the increased case loads. Insufficient staffing and funding for such a program in these areas is likely to lead to medication orders absent any other form of “high[] quality mental health care,” such as talk therapy, or necessary services, such as housing or job assistance. Implementation of this program also risks increased rationing of services over and above what is already caused by Medicaid demand, whereby those that voluntarily seek treatment will face even longer waits due to increased demand from involuntary consumers. And in terms of enforcement, the threat of hospitalization as a consequence for noncompliance may prove utterly unrealistic given the fact that there simply are not enough beds to go around. Therefore, either Jason’s Law should be amended to include adequate funding or it should be relegated to the legislative waste bin in lieu of a real overall increase in mental health care funding rather than simply allotting a larger piece of an ever-shrinking pie to community services.

VII. CONCLUSION

Returning to the case of Timothy Halton, Jason’s Law may have been able to provide him with the treatment he needed, but its breadth would unnecessarily infringe upon the rights of the non-dangerous mentally ill. Jason’s Law, and others like it, unduly restricts the liberty of the non-dangerous mentally ill without substantial legal or moral justification by casting a net that is far wider than necessary. Jason’s Law conflicts with established Ohio civil commitment statutes

185O’Connor, supra note 103, at 361-62. O’Connor questions the effectiveness of Kendra’s Law at preventing violence in light of two recent horrific events. Id. at 365-66. One man desperate for treatment pushed a woman in front of a subway train and another man ordered to assisted outpatient treatment, but whose case was closed because the county lacked the manpower to locate him, walked into a church service and opened fire, killing the priest and a worshiper. Id. In light of these incidents, preventative commitment’s promise of preventing violence is an empty one.


187See id.

188AM. ASS’N OF CMTY. PSYCHIATRISTS, supra note 55.

189See OHIO DEP’T OF MENTAL HEALTH, supra note 172, at 6. “On average, the daily occupancy rate was 91 percent across all nine state hospital sites during the second quarter of 2004.” Id.
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and case law by basing its criteria in unproven assumptions and faulty risk predictions and by unnecessarily interfering with the medical decisions of competent persons and their doctors. If Jason’s Law is to become law in Ohio, it must undergo substantial changes and provide substantially the same rights and protections as current Ohio law grants the mentally ill and must be adequately funded to provide a full range of services across the state.

In the interest of preventing violence, it may make sense to eliminate the imminent dangerousness requirement, but Jason’s Law goes too far by not requiring proof that the respondent has ever even threatened to harm self or others. Merely determining that a person is suffering from a mental illness, has been treated or hospitalized in the past, and has discontinued such treatment does not warrant intrusion by the state.

In our haste to act, we must remember that the majority of the mentally ill are not violent.190 Jason’s Law should be more narrowly tailored to apply only to those persons that have a history of violence as demonstrated by evidence of violent acts or threats, but who may not be presently dangerous, such as Timothy Halton. But, as written, the law could easily apply to someone who has never acted violently, simply because they have elected not to continue therapy or take medication. This is not acceptable. “Institutionalized discrimination against people with mental illness is one of the last socially acceptable, government sanctioned threats to the rights of a large class of citizens and makes the realization of self determination a tenuous and challenging process for many of them.”191 In our efforts to prevent violent behavior, we must acknowledge that it simply is not possible to prevent every conceivable act of violence, nor should we try to do so by tolerating expansive community control laws designed to oppress the rights of an entire class of people.

190See, e.g., Monahan, supra note 18, at 519; Friedman, supra note 18, at 2065.