CIVIL COMMITMENT IN OHIO

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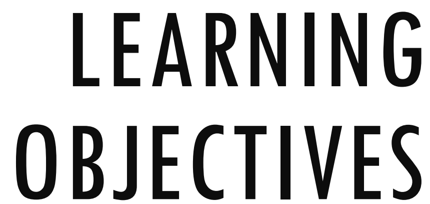


What theories justify civil commitment?

What are the clinical and judicial steps in the process?

What is wrong, and what is being done to remedy problems with the process and the law?

A BIT OF HISTORY...

IN COLONIAL AMERICA, PEOPLE WITH MENTAL DISORDERS WERE THE RESPONSIBILITY OF THEIR FAMILY OR FRIENDS

IF FAMILIES DID NOT HAVE THE RESOURCES TO CARE FOR SUCH INDIVIDUALS, THEY WERE BANISHED AND IF VIOLENT, OFTEN PUNISHED AS A CRIMINAL

1752 - 1773

Pennsylvania Assembly, in response to a petition from Benjamin Franklin, authorized the establishment of the first hospital to receive the sick who were poor.

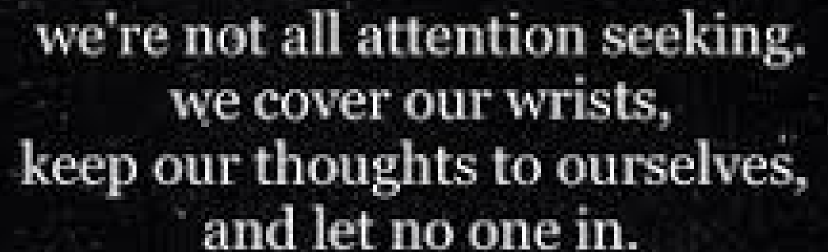
The first hospital devoted exclusively to the mentally ill who were poor is established in Virginia in 1773.

1788

New York passed a statute that authorized constables to procure a warrant and lock up the “furiously madd”, this for the duration of the individual’s dangerous condition

AND BY THE MIDDLE OF THE NINETEENTH CENTURY

Widespread adoption of the authority of states for civil commitment, not only for those who demonstrated a proneness to harm others but also for those who might harm themselves



REASONS FOR THIS EXPANSION OF COMMITMENT AUTHORITY?

As society became more interdependent and government more pervasive, the traditional view that the family was obligated to take care of its own became outmoded

A perception developed that techniques for care for people with a disability had improved

BUT..

In 1969 the Lanterman-Petris-Short Act made dangerousness to self or others the core criterion for commitment

Defined these criterion narrowly

Provided extensive procedural protections

In Wisconsin the *Lessard v. Schmidt* case prohibits commitment without proof of mental illness and dangerousness

WHAT IS THE STANDARD OF PROOF?

In 1979 the Supreme Court refused to hold that the criminal ***reasonable doubt standard*** is constitutionally required in the civil commitment context

The standard of proof, subjecting a person to involuntary commitment, is now by ***clear and convincing evidence***

See: Addington v. Texas

CONTEXT

Least restrictive doctrine

Improved psychotropic medications

Community mental health movement

Growth of private and veteran's hospitals

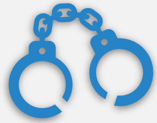
Government contracts with private companies and managed care companies

THE BASIS FOR STATE INTERVENTION…PART 1

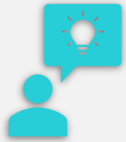
One of two purposes of contemporary civil commitment law is not to punish for past acts but to avert future ones (think: a prediction of conduct)

Contrast with criminal law where retribution or deterrence are paramount (think: already committed conduct)

THE POLICE POWER COMMITMENT



Preventative detention – confinement based on a prediction of antisocial behavior rather than a conviction of a crime – has been condemned on two grounds:



Predicting behavior is much more difficult

Imposing criminal liability in anticipation of harm probably violates the eight amendment's prohibition against cruel and unusual punishment

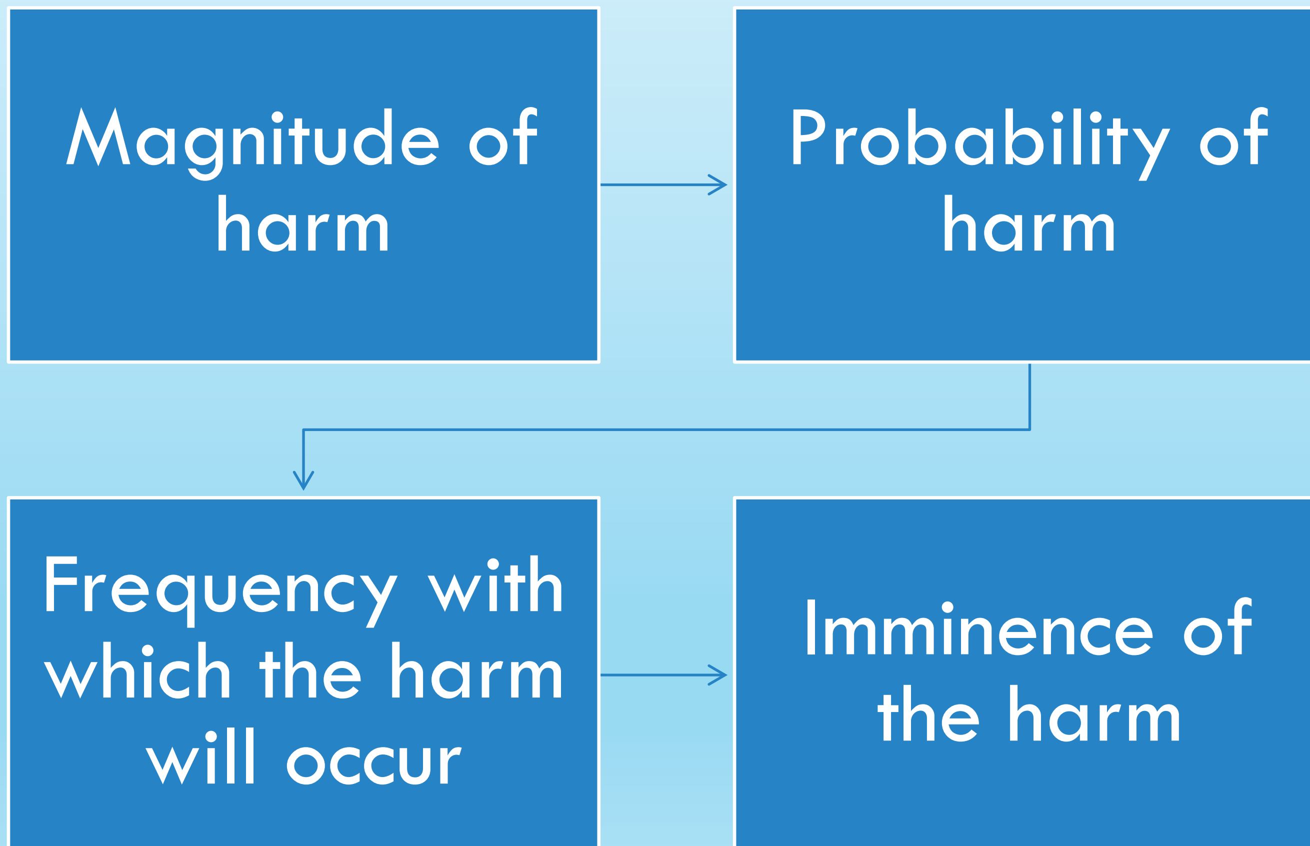
STATE STATUTES

Every state requires proof of mental illness or mental disorder as a predicate for police power commitment.

Generally, the approval of a requirement that the potential for doing harm must be "great enough to justify such a massive curtailment of liberty" *(Lessard v Schmidt)*

This implies a balancing test in which the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he/she will do immediate harm to self or others

STATE STATUES CAN BE BROKEN DOWN TO:



THE BASIS FOR STATE INTERVENTION.. PART 2

The **parens patriae** authority is based on the power of government to act as "parent" toward its citizens

Parens patriae is Latin for "parent of his or her country"

It empowers the state to act as guardian for those who are unable to care for themselves

PATERNALISTIC LAWS: A FEATURE OF MODERN LIFE

People with mental illness lack the capacity to make decisions about treatment and hospitalization?

As a class, people with mental illness are no more incompetent than others and should not be singled out for special treatment?

Should the state substitute its judgment about the necessity for hospitalization and treatment?

CASE LAW ADDS REFINEMENTS

O'Connor v Donaldson: The Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals

"To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process…"

CASE LAW ADDS A DOCTRINE

Almost all state statutes require the admitting authority to consider dispositions other than hospitalization. This is known as the least restrictive doctrine

It is used as a device for regulating treatment imposed on persons after they have been committed or otherwise subjected to state intervention

It is relied upon in asserting that the government has an obligation to create community-based services

THE CIVIL COMMITMENT PROCESS IN OHIO

1. Emergency Hospitalization under ORC § 5122.10

2. Often called a "pink slip"

3. Psychiatrist, licensed clinical psychologist, physician, health officer, parole officer police officer, certain advanced nursing licenses…

4. Take the individual into custody and transport them to a hospital

"PINK SLIP" LANGUAGE REFERENCES ONE (OR BOTH) OF THE PHILOSOPHIES FOR DETENTION

1. Represents a substantial risk of physical harm to self as manifested by evidence of, or attempts at, suicide or serious self-inflicted 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

AND….

OR…

3. Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision of those needs cannot be made immediately available in the community

4. Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself

ONCE AT THE HOSPITAL…

1. The patient must be examined within 24 hours to determine if, in the doctor's opinion, the patient requires treatment to ensure that they are not a danger to self or others

2. If the examining physician decides the patient requires treatment, the hospital can keep the patient for 3 court days after the initial examination

3. An affidavit is completed that asks the probate court to order mental health treatment for a person who meets specific legal rules for civil commitment

AND THEN…

The court reviews the affidavit and schedules a preliminary hearing within 5 days

The court may appoint an attorney if the individual does not have representation

The court sends notice to the parties and others as may be necessary

The court may order additional examination(s)

The court schedules a hearing to determine if probable cause exists to continue holding the patient

The Mental Health Board presents evidence that is clear and convincing that the individual requires treatment

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THE COURT MAY DECIDE:

Inpatient treatment is necessary. Typically another hearing is held approximately 30 days later, at which time the order may be discontinued, extended, OR…

You can request to become a voluntary patient, and, if you wish, give the hospital a 3 day notice letter indicating your desire to be discharged OR…

A new option is that the court may use a new category, and order OUTPATIENT TREATMENT which will then result in a clinical investigation by the local mental health board

The court can order outpatient treatment for 90 days, and then another hearing is held and the order may be continued

TO QUALIFY FOR AN OUTPATIENT TREATMENT COURT ORDER:

All five criteria must be met:

1. A clinician found that you are unlikely to survive safely without help

2. You have a history of not complying with treatment

3. You have been hospitalized or in a jail/prison within the past 3 years, or you have threatened or committed violence with the past 4 years

4. You are unlikely to voluntarily get treatment because of your mental illness

5. AND you need treatment to prevent getting worse and harming yourself or others

A RELATED CHANGE

The addition of court-ordered outpatient treatment was accompanied by a change in Chapter 5122

Formerly, the initial "pink slip" explained that the patient was **"subject to hospitalization"** under 5122.01 (if you met one or more of the four criteria)

The new language states that the person is a mentally ill person **"subject to court order"**

This allows the court to consider an order for outpatient treatment if the individual meets the five criteria

BUT....THERE ARE PROBLEMS.... LET'S REVIEW THE PROCEDURES

When a person believed to be mentally ill and who represents a substantial risk of physical harm to self or others may be taken into custody and transported to a hospital licensed to treat mentally ill persons by the Ohio Department of Mental Health and Addiction Services, or to a "General Hospital"

ORC § 5122.10 (A)

WHEN…

A determination is made as to whether a person should be taken into custody pursuant to § 5122.10(A), the person who makes such determination and who is responsible for taking custody of the mentally ill person (i.e., officer or practitioner) must give a written statement which specifies "the circumstances under which (the mentally ill person) was taken into custody and reasons for the belief that the person (was) a mentally ill person subject to court order and represented a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination". (§ 5122.10(B))

This statement/form is known informally as the "Pink Slip"

GENERAL AND LICENSED HOSPITALS

Persons taken into custody pursuant to § 5122.10 may be taken to either a "Hospital" as defined in § 5122.01 or a General Hospital not licensed by the ODMHAS. "Hospital" means a hospital or inpatient unit licensed by the ODMHAS, and any institution administered by the Department. The term "general hospital" is not defined in the ORC and is usually defined in terms of its general usage

And here is the problem:

When a patient is taken to a "general hospital" pursuant to § 5122.10, the patient must be transported to a "hospital" within 24 hours after arrival, without exception

BUT…

Facilitating a transfer within 24 hours is often impracticable

The patient may not be medically stable

There may be no available beds

This leaves the physicians at the general hospital with few options. The solution practiced by many physicians is to repeatedly "pink slip" the patient in order to secure their continuing detention as a preliminary exam within 3 days and a subsequent hearing, as required, is not possible

This practice violates the rights of the patient, it also has the potential to expose the general hospital or persons affiliated with the hospital to tort liability for false imprisonment

WHAT IS FALSE IMPRISONMENT?

In Ohio, the tort of false imprisonment is committed when a person confines another intentionally without lawful privilege to do so and against his or her consent within a limited area for any appreciable time, however short

There is provision in the ORC for good faith immunity (*see* ORC § 5122.34(A))for those involved in the hospitalization or discharge of persons hospitalized under § 5122.10. It requires acting in good faith and acting upon either actual knowledge or information thought by them to be reliable

SO SUE ME…

In Ohio persons who have been involuntarily detained under § 5122.10 have brought and litigated to judgment false imprisonment claims related to having been detained. The deciding factor in determining whether a false imprisonment claim relating to temporary emergency hospitalization under § 5122.10 will overcome statutory immunity under § 5122.34 has been whether the facility where the claimant was detained followed the procedure required under § 5122.10. In this case the peace officer did not complete a pink slip

The immunity provision in § 5122.34 does not extend to the patient who cannot be transported solely because they are not medically stable

THE WHITE SLIP IS BORN !

Some hospitals in NE Ohio engaged in risk management balancing: false imprisonment charge or the risk of a wrongful death claim after allowing the person to leave OR "how can we continue to detain a person involuntarily after the 4 day limit? (initial exam day + 3 days for additional exam and affidavit to court)

The "white slip" is good faith documentation. It contains a mental status exam and is completed by advanced licensed providers (M.D., Ph.D., LISW, APRN)

IT WORKS LIKE THIS…

Medically "competent" patients are permitted to refuse medical treatment. The assessment of "competency" is a hospital setting is not a legal determination of a patients' competency, but an evaluation of a patient's decision-making capacity. At a minimum, a medically "competent" patient must be able to understand the risks, benefits and alternatives to treatment.

The evaluation of capacity provides an assessment of whether the patient appears at the time to have diminished decision-making capacity. If so, the patient will not be permitted to leave the hospital. Subsequent treatment must follow an established treatment plan, in the least restrictive setting, and in compliance with the patient's rights. The pink slip may be completed **no sooner** than 24 hours prior to transfer to a psychiatric inpatient unit or hospital.

DOES THIS WORK?

Will it withstand a false imprisonment claim?

When does the 24 hour / 3 day evaluation clock begin? When admitted to general hospital or when finally transferred to psychiatric unit?

Can it be used with the “merely demented”?

AMEND THE STATUTE?

Add this language to the existing statute:

"If, however, the person taken into custody and transported to a general hospital under this section is not medically stable at the end of seventy-two hours after arrival at the general hospital, the general hospital may continue to provide care and treatment for the person, or both, until the person is deemed to be medically stable by an attending physician before transferring the person to a hospital as defined in Section 5122.01 of the ORC"

AND NOW THIS …

Recently passed Ohio House Bill No. 7 which included the following statutory immunity language, and now appears to have been deleted in the final version of the bill:

"Notwithstanding any other provision of the Revised Code, a physician, physician assistant, advanced practice registered nurse, or hospital ***is not liable in damages*** in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority for doing either of the following:

NUMBER ONE:

“Failing to discharge or to allow a patient to leave the facility if the physician, physician assistant, advanced practice registered nurse, or hospital believes in the good faith exercise of professional medical, advance practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice that the patient has a mental health condition that threatens the safety of the patient or others”;

AND…

NUMBER TWO:

"Discharging a patient whom the physician, physician assistant, advanced practice registered nurse, or hospital believes in the good faith exercise of professional medical, advanced practice registered nursing, or physician assistant judgment according to appropriate standards of professional practice not to have a mental health condition that threatens the safety of the patient or others."

1. The MHPAEA
2. Ohio law
3. Enforcement process
4. Enforcement trends
5. Wit v United Behavioral Health ("UBH")

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

1. Generally requires that mental health conditions and substance use disorders be treated by a health plan in the same or similar manner as the plan treats benefits for medical and surgical conditions and disorders

2. Financial requirements (co-pays, deductibles, out-of-pocket max. limitations should be no more restrictive than for med/surg benefits)

3. Treatment limitations – prior auth requirements, visitation limits or treatment settings … may be no more restrictive than for physical medicine benefits

OHIO'S PARITY LAW

Ohio Revised Code Sec. 3923.281 –

Every policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders

Ohio Revised Code Sec. 3923.282

Health coverage plans must cover biologically based mental illness on parity with other illnesses

NOW THE DOL REALLY MEANS IT

The main enforcement entity is the Employee Benefits Security Administration's Office of Enforcement or EBSA, an agency within the Department of Labor

CMS enforces MHPAEA and other provisions of Title XXVii of the Public Health Service Act with respect to non-Federal governmental health plans, such as plans for employees of state and local governments

Numerous state AGs have shown recent increased interest in the issue and may also choose to use their enforcement powers under their own state's parity laws

EBSA INVESTIGATIONS: 2021

Annual dollar limits and aggregate lifetime dollar limits

Benefits in all classifications – must be provided in every category that medical surgical benefits are provided

Financial requirements: deductibles, copayments, coinsurance and out of pocket costs

Treatment limitations: quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs)

FUN INVESTIGATION FACTS…

This is where the speaker lists a bunch of facts involved in several investigations.

HOW WIT V. UNITED BEHAVIORAL HEALTH COULD IMPACT THE FUTURE OF MENTAL HEALTH PARITY

Basic facts:

1. A class action suit under ERISA. Several plaintiffs in several different states. Suit filed in the Northern District of California, 2019

2. Benefits denied: inpatient, SUD treatment and residential. Adults and adolescents

1. Breach of fiduciary duty

2. Arbitrary and capricious denial of benefits based on a facial challenge to UBH's Level of Care Guidelines

3. Plaintiffs argued that these Guidelines did not comport with generally accepted behavioral health standards of care

ACCORDING TO THE PLAINTIFFS

UBH breached its fiduciary duty to members by:

1. developing guidelines for making coverage determinations that are far more restrictive that those that are generally accepted even though Plaintiffs' health insurance plans provide for coverage of treatment that is consistent with generally accepted standards of care; and…

2. prioritizing cost savings over member's interests

WHAT DID THE COURT THINK?

The Court explained that the preponderance of the evidence showed that the ***only*** reason UBH declined to adopt criteria following the generally accepted standards of care, despite a clear consensus among UBH's addiction specialists that those generally accepted standards of care criteria were preferable to UBH's own Guidelines, was that its Finance Department wouldn't sign off on the change

The Finance Department had veto power with respect to the Guidelines and used it to prohibit even a change in the Guidelines that all of its clinicians had recommended

The district court ordered UBH to re-process more than 60,000 claims that had been initially denied for not meeting UBH's medical necessity guidelines

AND THEN

Upon appeal to the U.S. Court of Appeals for the Ninth Circuit:

1. It reverses the district court's order requiring UBH to re-process more than 60,000 claims

2. In the view of the Ninth Circuit, the District Court misapplied the standard of review. The UBH plans conferred upon UBH discretionary authority to interpret the terms of the plan. The proper standard to be applied by the District Court was to review the plan administrator's decisions for an abuse of discretion. The Ninth Circuit held that the district court misapplied this standard by "substituting its interpretation of the plans for UBH's". There was no explanation of how the standard was misapplied

THE DECISION ENDS ABRUPTLY WITH THE FOLLOWING:

“Even though the Plaintiffs argued quite extensively in their briefing that the abuse of discretion standard should be given a decreased level of deference in light of a clear conflict of interest…

Furthermore, even if UBH has a conflict of interest because it serves as plan administrator and insurer for fully insured plans that are the mains source of its revenue, this would not change the outcome on these facts”.

WHAT THE 9TH CIRCUIT LEFT UNANSWERED

A whole lot:

1. Does not address plaintiffs' discriminatory application argument; what facts they paid particular attention to and which facts they ignored

SO WHAT HAVE WE LEARNED:

1. Look at conflicts of interest

2. The balance between financial considerations and proper care for patients that goes into **creating** a plan's guidelines

3. The balance between financial considerations and proper care for patients that goes into **applying** the plan's guidelines and the medical decision-making process

GUNS AND THE MENTALLY ILL

In 2008, the U.S. Supreme Court decided in the case of *Heller v. District of Columbia* that "…nothing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by felons and the mentally ill"

Subsequent extensive research found no evidence of these "longstanding prohibitions"

IN FACT

Federal law, like most state laws, does not prohibit the possession of a firearm by a person with a mental illness, even if they are a danger to themselves or others, unless they have been deemed so by a court or adjudicatory body

That interpretation, across most state laws means: involuntarily hospitalized or committed to a mental health or substance abuse treatment facility by a court, commission, or other lawful authority

THE PROBLEMS…

If a court or a lawful authority is not involved, there is no law against obtaining a firearm

It does not include anyone admitted to a mental institution voluntarily or for observation

This restriction on ownership amounts to a lifetime ban without any available due process to seek reinstatement of Second Amendment Rights

IN OHIO

Ohio has no laws requiring the report of mental health information to the National Instant Criminal Background Check System ("NICS"). Ohio requires a probate judge who finds an individual to be a mentally ill person subject to hospitalization by court order to notify the Bureau of Criminal Identification and Investigation ("BCII") of the identity of the individual. Similarly, the chief clinical officer of a hospital, agency, or facility has the same notification requirements, unless the patient is voluntary or an observation patient. The notification must be transmitted by the judge or the officer no later than seven days after the adjudication or commitment

RANT...

Verb

To speak or shout at length in a wild, impassioned way

WHY CAN'T ONE BE REGULATED LIKE THE OTHER????

MENTAL HEALTH, MEET VENTURE CAPITAL

The private sector has taken notice of an economic mismatch (high demand with inadequate supply) and is aggressively pursuing mental health and wellness as an investment opportunity

In 2019 VC companies invested 637 million in more than 60 different mental health-oriented companies. A 23% increase from 2013

Calm, a smartphone app focused on audio-guided meditation, reached a milestone valuation of more than $1 billion

Since COVID-19, private investors have poured more than $ 3.1 billion by the 3rd quarter of 2021

WHY? AND WHAT?

Pandemic unleashes enormous mental health needs: CDC data show an increase in anxiety and depression from 11% in 2019 to 42% in 2020. Demand is high. Supply is low.

7 companies valued at more than $1 billion

Over 20,000 mental health apps currently circulating

Brick and mortar companies open new facilities or buy existing facilities and practices or MSOs operate existing providers

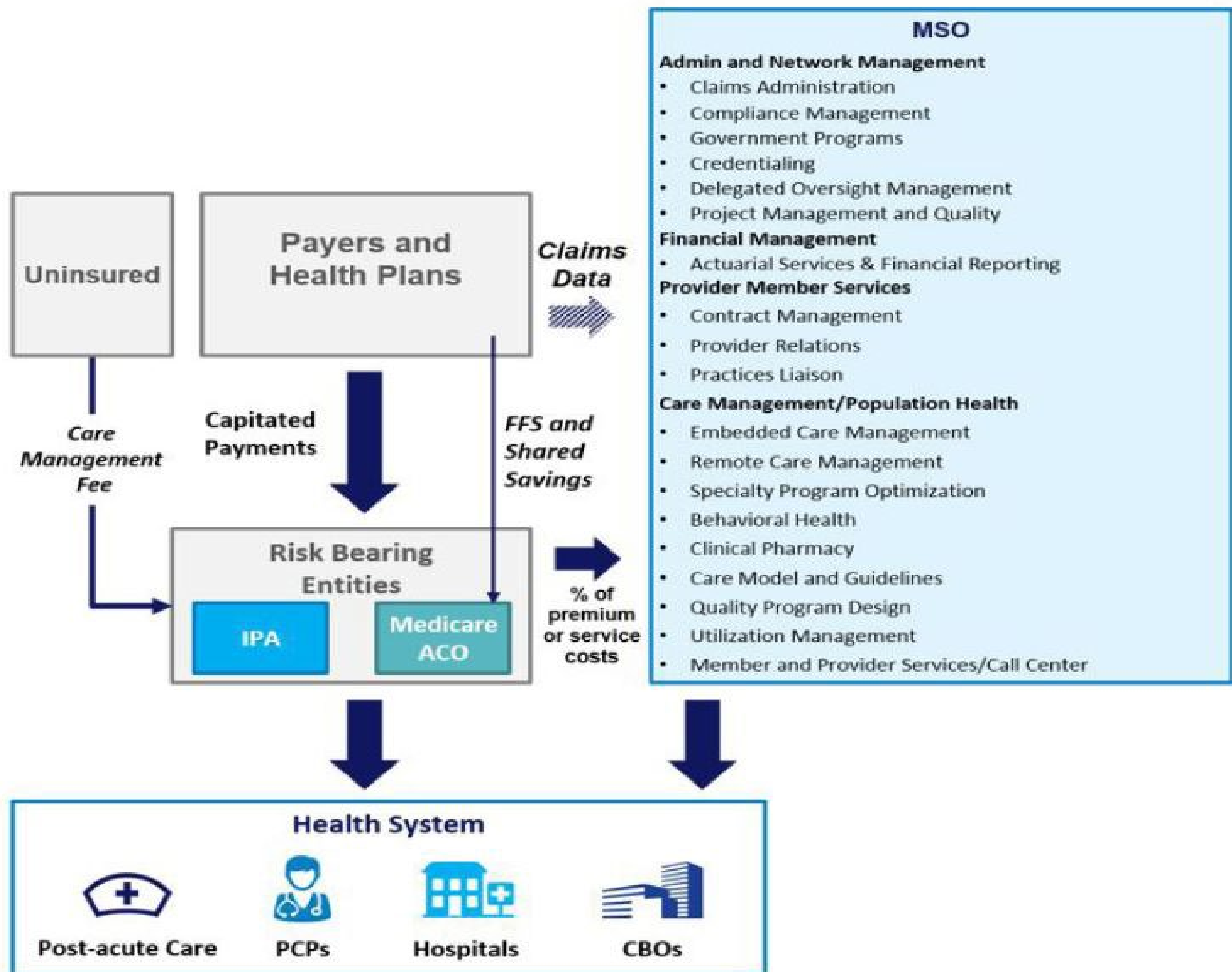

Image 1. Illustration of a Health System with an MSO (blue shaded box) providing essential administrative and management functions.

PROBLEMS REMAIN

Is the rise in funding a fad that will disappear once the pandemics are better controlled or when people tire of using these products?

Without regulation, how can people choose interventions that effective?

Uptake? Of the 93 most frequently installed apps, those that rely on user motivation – just 3.9% of initial users continued using them after 14 days

How to address issues of diversity, equity and inclusion? The people we hope would benefit the most from expanded access are often the least likely to purchase and use these technologies

MORE TRENDS

Employee mental health and well-being is becoming a budget line item

Employee resource and affinity groups are becoming commonplace

Mental health will become dinner table dialogue and an increase in mental health education for students

Social determinates: how an individual's personal circumstances impact what health care they receive

Reintegration of behavioral and physical medicine

Stretching the continuum: diversion/crisis receiving centers

AND MORE TRENDS

Trauma-informed care: 61% of adults have experienced at least one traumatic event in their lifetimes. One in six adults have four or more…

Blood tests for mental illness: Indiana School of Medicine develops novel blood test…biological markers for mood disorders are found in RNA biomarkers…

Psychedelics as treatment tools: FDA authorizes increases in production of psychedelics to meet growing research demands…

Social media: are these platforms harmful? Do we need digital wellness?

Telehealth: where are we now…or better said…today?

OH…DON'T FORGET

How about that labor market? Where are the staff? Quiet quitting?

And now, for your relaxation and financial enjoyment: the signs of an aggressive audit environment are everywhere. HHS allocates a staggering $2.6 billion to increase audit efforts to fight fraud and abuse

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THANK YOU

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