Ohio A.O.T.
Implementation Manual

Developing an Effective Assisted Outpatient Treatment Program

Treatment Advocacy Center
Northeast Ohio Medical University
NAMI Ohio
National Alliance on Mental Illness
The State's Voice on Mental Illness
The Margaret Clark Morgan Foundation

Dear Colleague,

While several Ohio counties have used assisted outpatient treatment (AOT) extensively for many years, until recently it has been little used in most of the state. We hope that is changing. It is not a magic bullet to cure the ills of our underfunded mental health system, but AOT is a tool that ADAMH Boards can use to help individuals at high risk engage in treatment and ultimately live successfully in our communities. After extensive review of the literature, the American Psychiatric Association recently concluded: *"Involuntary outpatient commitment programs have demonstrated their effectiveness when systematically implemented, linked to intensive outpatient services and prescribed for extended periods of time."*

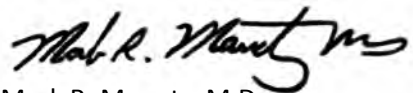
The time to implement AOT in Ohio's 88 counties is now. The 2014 revision of Ohio's civil commitment law (S.B. 43) added new avenues and important detail to the AOT process, making it clear that our lawmakers want to see this tool used. They were moved to action by compelling evidence of how effective it has been, in certain Ohio counties and other states, in helping people with severe mental illness avoid tragic outcomes.

Implementing AOT, however, is not just a matter of a probate court issuing orders. It requires a concerted community effort involving a ***commitment*** (using that word purposely) from the leadership and staff of the probate court, law enforcement, local and state hospitals and community mental health agencies.

This manual describes the components and operational steps to implement an effective AOT program. If your county does not yet practice AOT, you may find the details overwhelming. We urge you not to be discouraged. While a fully realized AOT program as described in this manual is our aspiration for every county, we recognize that few if any counties are likely to put every piece in place, especially in the early stages. But the "core elements" presented here offer some basic principles and concepts to get you off on the right foot. Key partnerships across systems are essential. Details like extensive data collection are likely to come much later. We hope this manual will encourage and inspire you to move your county forward. It can and must be done!

And please keep in mind that you need not be alone on this journey. The producers of this manual -- our team at NEOMED and our friends at the Treatment Advocacy Center -- are readily available for technical assistance, advice, site visits, presentations, etc.

Sincerely,



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For NEOMED, Amy Lukes and Dr. Mark Munetz were the primary contributors; for TAC, Betsy Johnson and Brian Stettin. We were aided immensely by background work on Ohio's civil commitment law by Heather Pokrandt, Christian Ritter and Erica Matthews, all of NEOMED. We are also grateful for input from Judge Robert G. Montgomery and Dr. Delaney Smith of Franklin County; Judge Elinore Marsh Stormer and Dr. Doug Smith of Summit County; Judge Laura Gallagher of Cuyahoga County; Magistrate Patricia Hider and Nick Schrantz of Butler County; Robin Reaves of Seneca, Sandusky and Wyandot Counties; and the countless others across Ohio who have asked questions and shared ideas while working with us to develop their own local AOT programs.

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Introduction

"Assisted outpatient treatment" (AOT) – sometimes known as "court-ordered outpatient treatment" or "outpatient commitment" – is the practice of placing individuals with severe mental illness and a history of struggling with voluntary treatment adherence under court order to follow a prescribed treatment plan while living in the community. Across the nation and here in Ohio, studies have shown that AOT can dramatically improve treatment outcomes -- substantially reducing the likelihood of repeat hospitalization and/or criminal justice involvement -- for its target population.

But for a variety of reasons, most of America's public mental health systems have yet to adopt AOT as a strategy for meeting the needs of their most challenging patients. Ohio is typical of most states, in that AOT has been practiced for many years in a small number of counties with excellent results, while rarely or never employed in most counties. In 2014, Governor John Kasich signed SB 43, legislation designed to encourage wider use of AOT by adding new eligibility criteria and clarifying the legal and clinical procedures by which an individual is court-ordered into treatment, monitored while under court order, and aided in the event of non-adherence. The enactment of SB 43 has clearly kindled new interest in AOT across Ohio. The challenge now is to translate interest into action.

This manual is intended to guide local teams comprised of Alcohol, Drug Addiction and Mental Health (ADAMH) Board officials, providers of hospital and community-based care, and probate judges in the establishment and day-to-day operation of AOT programs. With all of these stakeholders committed and engaged, any county in Ohio has the capacity to successfully practice AOT. Herein we present what we consider the core elements of achieving this. At the same time, we recognize that no two counties will implement AOT in exactly the same way. Beyond the core elements is a need for tailoring to fit local circumstances and constraints. We hope this manual will help demystify AOT and inspire all Ohio counties to implement this life-saving program.

At the outset, we offer two important clarifications:

CLARIFICATION # 1: WHAT WE MEAN BY "AOT PROGRAM."

The word "program" does not appear in any of the Ohio statutes concerning "court-ordered outpatient treatment." Under state law, AOT is nothing more than a legal procedure which may be employed in the case of a *specific individual* who meets certain criteria. It would certainly be possible for a local mental health system to think of AOT strictly in these terms, i.e., as an option to be employed from time to time, initiated by a family member or frustrated caregiver, when traditional service delivery models have failed. While such willingness to employ AOT on a case-by-case basis is preferable to not using AOT at all, in this manual we are describing how to do something more ambitious and more likely to yield far-reaching benefits. That is, we are calling on each county mental health system, under the leadership of the ADAMH Board, to make the greatest possible use of the AOT law by establishing a local AOT *program*. By "program", we mean a systematic, organized effort to:

- identify the *entire subset* of individuals with serious mental illness within the service area who appear to be "stuck in the revolving door" as a consequence of their inability to adhere to treatment on a voluntary basis (usually due to lack of insight);
- ensure that whenever such an individual is identified as meeting criteria for AOT, *the mental health system itself*, rather than relying on families to use the AOT law, takes the initiative to apply to the court for AOT; develop a comprehensive community-based treatment plan and secure providers for the individual; and present the evidence in court;
- safeguard the due process rights of patients at all stages of the AOT proceeding;
- facilitate the attendance of patients at all AOT hearings so that they may receive motivational instruction and encouragement from the judge;
- provide intensive case management to AOT patients, in order to encourage and monitor treatment adherence and the full delivery of all court-ordered services;
- employ specific protocols to respond in the event that an AOT patient does not comply with the court order;
- evaluate each AOT patient at the end of the court order period, to determine whether it is appropriate to seek renewal of the order or allow the patient to pursue voluntary treatment.

CLARIFICATION # 2: AOT IS NOT "MENTAL HEALTH COURT"

AOT is often confused with the related practice known as "mental health court." The essential difference is that AOT

is a form of *civil* commitment imposed by a civil procedure, and does not require the commission of a crime as the price of admission; a "mental health court" is a *criminal court*, offering community-based treatment as a means to divert defendants with mental illness out of the correctional system.

To be sure, we regard mental health court as an equally essential component of an enlightened mental health system. But we disagree strongly with any suggestion that having a mental health court eliminates or reduces the need to offer AOT in the same community. AOT addresses the needs of at-risk patients *before* crimes are committed. If court-ordered treatment is available only to those who break the law, the consequence will be needless victimization – often by acts of violent crime that are too serious for diversion to mental health court. (And, of course, many individuals who stand to benefit from AOT will never end up in mental health court because they tend to victimize only themselves and do not commit crimes.)

A list of key items necessary for successful implementation of AOT is attached in Appendix I. Key stakeholders, including judges, magistrates, mental health professionals, advocates and administrators have provided input and identified core components for effective AOT programs. The focus of any AOT program should be to provide the care those with severe and persistent mental illness need to live successfully in the community setting. The core elements have been developed with mission in mind and are described below in detail.

Core Element 1: Program has buy-in from key leadership.

The launch of a new AOT program should begin with the coming together of key leaders of the treatment system, law enforcement, and judiciary for the purposes of planning and needs-assessment. The planning process will benefit from these leaders' strong knowledge of the community and its existing resources and challenges. Membership should include:

- ADAMH Board Executive Director and Chief Clinical Officer
- ADAMH Board attorney
- probate judge and/or magistrate
- sheriff and/or police commander
- treatment providers, including community mental health (case management and medication management), inpatient psychiatric services, psychiatric emergency services, etc.
- peer/family advocate

Each of these stakeholders represents a link in the chain of a well-functioning AOT program; failure to secure "buy in" from any one could prove fatal to the entire venture. Each individual or entity must fully recognize and embrace its role in the process:

ADAMH Board Executive Director and Chief Clinical Officer (CCO): Under the Ohio AOT law, the Chief Clinical Officer (or his/her designee) of the entity to which the patient is committed is primarily responsible for the treatment. The common (and recommended) practice in Ohio is to commit the patient to the ADAMH Board of the county of residence so that transitions between levels of care can be effectively monitored. This places responsibility on the Board's CCO to assure that the community providers meet the requirements of the statute, including development of a treatment plan that focuses on engagement, provision of appropriate treatment and regular (at least monthly) review to assure the patient is being treated in the most appropriate level of care.

Attorney for the Board: The attorney for the ADAMH Board is responsible for making the case for AOT to the court. He or she gathers evidence from the affidavit, subsequent investigation, and those testifying on behalf of the Board. During the hearing, the attorney presents this evidence by introducing documents and examining witnesses. The attorney is also responsible for filing motions to the probate court, including requests for hearings, requests for evaluation for hospitalization, and motions to continue and discontinue court orders.

Probate Court Judge and/or Magistrate: The probate judge is responsible for the judicial procedure outlined in the statute. He or she assures that timelines are met, including notices and hearings. Hearings are conducted following the standards of due process. The legal burden of proof for a finding that an individual is a "mentally ill person subject to court order" is "clear and convincing evidence." The judge (or magistrate) will typically rule on the finding during the hearing.

Just as important as these procedural functions is the probate judge's role as the primary motivator of the AOT patient. It is often said that AOT relies upon a "black robe effect." The theory is that even those who are disinclined to heed their doctors' instructions will feel duty-bound to follow the edict of a judge. To maximize the black robe effect, once the judge is satisfied that AOT is appropriate, he or she should use the hearing as an opportunity to impress upon the patient that treatment adherence is expected and essential to avoiding re-hospitalization.

Outpatient Treatment Provider: The treatment agency's primary responsibility is to engage the patient in the prescribed care, using the court order as leverage, with the ultimate goal of having the patient accept treatment voluntarily. Once the AOT order is in place, the provider works with the patient to develop a treatment plan, detailing the services necessary for the patient to maintain stability. At a minimum, these will include case management and medication management. The treating psychiatrist will monitor the patient and provide necessary documentation to support the Board attorney's motions to the probate court. The treatment agency provides

a report to the Board's Chief Clinical Officer (or a CCO-appointed probate monitor) at least monthly addressing the patient's progress, adherence, and continued need for the court order.

Crisis Center or Psychiatric Emergency Department Administrator: If an individual named in an affidavit is unwilling to participate in a psychiatric examination, an emergency order of detention requires law enforcement to transport the individual to a crisis center, emergency room or other prescreening locations for evaluation. The evaluation must occur within 24 hours, or the individual must be released. The report of the examination is filed with the court to be used in making a determination. Moreover, if a patient under AOT is non-adherent to treatment and begins to show behaviors indicating deterioration in mental status, such patient may also be ordered to the crisis center or psychiatric ER for evaluation.

Inpatient Treatment Provider: The hospital may begin the commitment process by filing the affidavit for court-ordered inpatient treatment under one or more of the first four criteria of the Ohio civil commitment law (see discussion below). It is common for hearings to be held at the hospital. In this case, the chief clinical officer of the hospital will file the affidavit and provide the evidence for commitment. Generally, the treating psychiatrist will testify at the hearing on the diagnosis, treatment course and prognosis of the patient. The hospital notifies the court when a patient under court order is discharged to a less restrictive setting (AOT). The hospital must be willing to accept back to the unit an AOT patient committed under one of the first four criteria who may not meet the usual criteria for emergency hospitalization, but is clearly exhibiting signs of deterioration.

Sheriff/Law Enforcement: As the law enforcement arm of the court, the sheriff is responsible for serving subpoenas and executing temporary orders of detention. In some jurisdictions, a police department may take on these responsibilities. Police also play a vital role in helping to monitor AOT patients in the community, particularly those officers assigned to Crisis Intervention Teams (CIT). Lines of communication should be maintained between police and AOT case managers, to facilitate an appropriate response to any observed behavior suggesting treatment non-adherence.

Peer/Family Advocate: Client advocates and peer supporters assure that the process is responsive to the needs of those it serves. Peer supporters have lived experience with mental illness and are extremely valuable in the engagement of the patient. They may themselves have been through the AOT process and furthered their recovery. Client advocates provide energy to the initiative and community education activities. They hold the AOT Program accountable to the community.

Core Element 2: Representatives of key stakeholders meet regularly.

After AOT is launched, a group representing each of the stakeholders listed above (but not necessarily including the agency leaders as recommended above for the planning of the program) should continue to meet periodically for purposes of program evaluation and improvement. Meeting on a regular basis will assist with identification of gaps in services, best methods for maintenance, and continual discussion of ways to improve the program. Meetings should be held at least quarterly; greater frequency may be required in the initial years of the program, or to accommodate interest in engagement from community members.

Having a variety of collaborators in discussion and planning is vital and will ensure that policies and procedures meet the needs of the local community and fold into the day-to-day workflow. Identifying an interdisciplinary team that includes administrators, clinicians, court personnel, local community organizers and consumers is essential to building an effective program. Teams should meet in advance to discuss the processes and implementation timeline.

Core Element 3: Agreed-upon written policies, procedures and forms are in place.

Policies and procedures should be discussed and finalized by work groups prior to the program launch. These procedures may include task flow diagrams, job descriptions, organizational charts, list of contacts and sample educational materials. (Several examples are included in the Appendices.) Policies and procedures should also include any anticipated pathways of care, written in a manner that is understandable to all involved. Locally-tailored documents should set forth processes for involuntary commitment, hospital discharge care planning, and the transfer of patients to more restrictive treatment settings.

Forms for tracking, assessment and monitoring progress are also vital to successful AOT programs. Similar to a clinical health record, documentation over the life of a patient can tell a story and assist with planning.

Proper routing forms are essential to appropriately monitor AOT patients. Moreover, a well-designed transfer form --- facilitating collaboration between providers to maximize continuity of services -- is necessary to ensure the smooth transfer of a patient to an alternate jurisdiction.

Core Element 4: An assigned professional serves as a liaison between the treatment team and the court.

The ADAMH Board's Chief Clinical Officer is responsible under the statute for monitoring the status of an AOT patient. This monitoring may be delegated to a "probate monitor." The role of the probate monitor is integral to an AOT program's ability to coordinate patient care, maintain the progress of each patient through the court system, and monitor outcomes. This role is distinct from both the treatment team and the court. The probate monitor keeps the two in communication and serves as each side's point of contact. The role should be designed as the driver of the AOT program, ensuring that the needs of each patient are met while patients meet their commitment of participation in the program.

Duties of the probate monitor include tracking all journal entries from the probate court, ensuring that all due resources are available to the patient, and identifying and addressing any barriers to service access that patients may encounter. The probate monitor is a resource to the treatment team; he or she assists in making sure evaluations are performed on time and resolves disputes between agencies. But it must be understood by all that the probate monitor is not a *member* of the treatment team; he or she is responsible for assuring the services provided are aligned with the patient's needs.

In larger jurisdictions, the probate monitor may be housed at the ADAMH Board. Some jurisdictions in Ohio contract the role out to a provider agency. This position can be part or full time depending on the needs of the county.

Core Element 5: AOT education is provided to stakeholders and the community at large.

Community engagement regarding the benefits and the process of AOT should be initiated prior to program launch and repeated periodically. This will help ensure that all stakeholders are invested in the success of the program and will assist in identifying AOT candidates. Target audiences should include:

- Staff at agencies serving AOT patients
- Family, caregivers
- NAMI affiliates
- Law enforcement (roll calls)
- Consumer-operated services
- Psychiatrists practicing outside the community system

Core Element 6: Patient outcomes, individual/family satisfaction, and gaps in resources are systematically tracked for purposes of program evaluation.

Utilization of tracking tools can assist with measuring success and identifying opportunities for program improvement. It can also assist with cost/benefit analysis of programs if items are tracked consistently over time. Teams need to consider capacity for the number of items tracked while in the planning stages. Examples of tracking tools are included for your review. It is recommended that patients continue to be tracked after completing AOT, to measure the sustainability of gains achieved under the program. Key data include:

- Historical commitment dates/length of commitments
- Hospitalization history (i.e. inpatient stays at state/local hospitals, crisis units, etc.)
- Requests for emergency evaluations
- ER visits
- Criminal justice history
- Housing history
- Employment history
- Treatment costs

Evaluation of family and client satisfaction is also important in maintaining the program in the long term. It is recommended that a neutral party be engaged to conduct a survey, to ensure honesty of responses. Areas of evaluation may include:

- Interactions during court proceedings
- Interactions during treatment team meetings

- Quality of information about the program provided to patient
- Patient's level of confidence that their integrity/privacy was protected
- Benefits of participation in program
- Suggestions for improvement

Core Element 7: There are established methods for identifying and addressing gaps in resources and areas for improvement.

AOT programs track data from a variety of sources, including the tracking and surveys discussed above, to review for deficiencies in the program and resource gaps, and develop and execute performance improvement plans. Treatment staff are also an important source of this information, which should be systematically reported to the stakeholder group in an anonymous manner. Regular stakeholder meetings should be used to develop strategies for improvement.

Client and community needs change over time. Programs should expect to continually adapt to maintain their good results.

Two Avenues to AOT

The Ohio civil commitment law provides two basic approaches that a mental health system may take to identify AOT-eligible patients and direct them into its AOT program:

(1) The patient whose current risk of harm can be addressed by AOT (first four criteria)

The first avenue, which has long been authorized under Ohio law, begins with the identification of a person who meets one of the four basic criteria for mental health commitment generally (either inpatient or outpatient):

OHIO REV CODE § 5122.01(B). "Mentally ill person subject to court order" means a mentally ill person who, because of the person's illness:

(1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
(2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
(3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; [or]
(4) Would benefit from treatment for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person;

In essence, a person found by the probate court to meet any of these criteria is deemed to present a risk to self or others *in the present moment*, and is committed to the authority of the local ADAMH Board for placement in the least restrictive appropriate treatment setting. At the discretion of the Board, this will usually mean involuntary placement in a hospital, or it may mean involuntary commitment to a program of outpatient care (i.e., AOT).

Under the longstanding practices of AOT programs in Ohio, it typically means a combination of the two: an individual in mental health crisis is evaluated and brought to court under the "pink-slip" process (described below), and, if found to meet any of the four criteria listed above, is committed to the authority of the Board and placed in hospital care. Once the individual has been stabilized in the hospital to the point that he no longer requires hospital care, the Board exercises its continued authority over the individual to release him onto AOT for the remainder of his period of court-ordered commitment. At the conclusion of this period, the Board may seek to renew the commitment so that it may continue providing AOT for an additional period of time.

As should be clear, an underlying premise in maintaining AOT under these circumstances is that throughout the period of outpatient commitment, the Board continues to believe that the patient presents a risk of harm to self or others, albeit a risk that has been diminished during the hospitalization period such that court-ordered community-based treatment is now appropriate to address it.

In **In re Burton**, 11 Ohio St.3d 147 (1984), the Ohio Supreme Court affirmed the appropriateness of maintaining the civil commitment of a patient whose condition has stabilized with hospital treatment. The court acknowledged that commitment might sometimes be appropriate for an individual whose "mental illness is in a state of remission," if there is cause for concern as to whether "the individual will continue treatment to maintain the remissive state of his illness should he be released from commitment." Among the factors to be considered in evaluating an individual's ability to avoid becoming dangerous to self or others, the court listed "whether the person has insight into his condition so that he will continue treatment as prescribed or seek professional assistance if needed."

Because this approach to AOT relies on the patient's commitment to the Board rather than to any particular treatment setting, it allows the treatment team total flexibility to determine the appropriate setting as

circumstances change. A patient may be transferred at will from inpatient to outpatient care without the need to seek court approval each time. The patient does retain the right to a hearing upon being rehospitalized.

A potential pitfall of this approach to AOT is that if the patient's only exposure to the court comes at the hearing held prior to hospital commitment, the judge has no opportunity to instill in the patient a sense of duty to adhere to the treatment plan upon his eventual release. At a commitment hearing upon initial hospitalization, a patient is typically in the throes of psychosis, and has little or no ability to absorb the judge's instructions. The obvious remedy is to make it a standard practice, very shortly after a still-committed patient is released from the hospital to outpatient care, to mandate the patient's appearance in court for a "status hearing" on the pending order. At this time the court should have the attention of a stabilized patient who hopes to avoid re-hospitalization and will take the judge's instructions to heart.

(2) The patient who, irrespective of current risk of harm, requires AOT based on a history of treatment non-adherence (fifth criterion)

The other potential avenue to AOT, added to Ohio law in 2014, is the so-called "fifth criterion" commitment:

OHIO REV CODE § 5122.01(B). "Mentally ill person subject to court order" means a mentally ill person who, because of the person's illness:

(5)

(a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:

(i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

(ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:

(I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.

(II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.

(iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

Unlike the first four criteria discussed above, a civil commitment under the fifth criterion may not be grounds for involuntary hospitalization. It may only be relied upon to commit the individual to AOT. Note that nothing in the fifth criterion necessarily relates to the individual's *current mental condition*. In contrast to the four preceding commitment criteria, it amounts not to a finding that the individual presents a current risk of harm to self or others, but rather that, based on past history and durable aspects of the individual's mental illness, there is reason to believe that the individual is currently unable to avoid *future* risk by adhering to necessary outpatient treatment on a voluntary basis.

It is generally understood that the legislature intended the fifth criterion to be utilized as a lesser remedy for an individual avoiding treatment in the community and clearly on the road to commitment under one of the first four criteria, but not yet a risk to self or others at the present time (i.e., not eligible for hospital commitment under any of the first four criteria). In such situations, if the individual

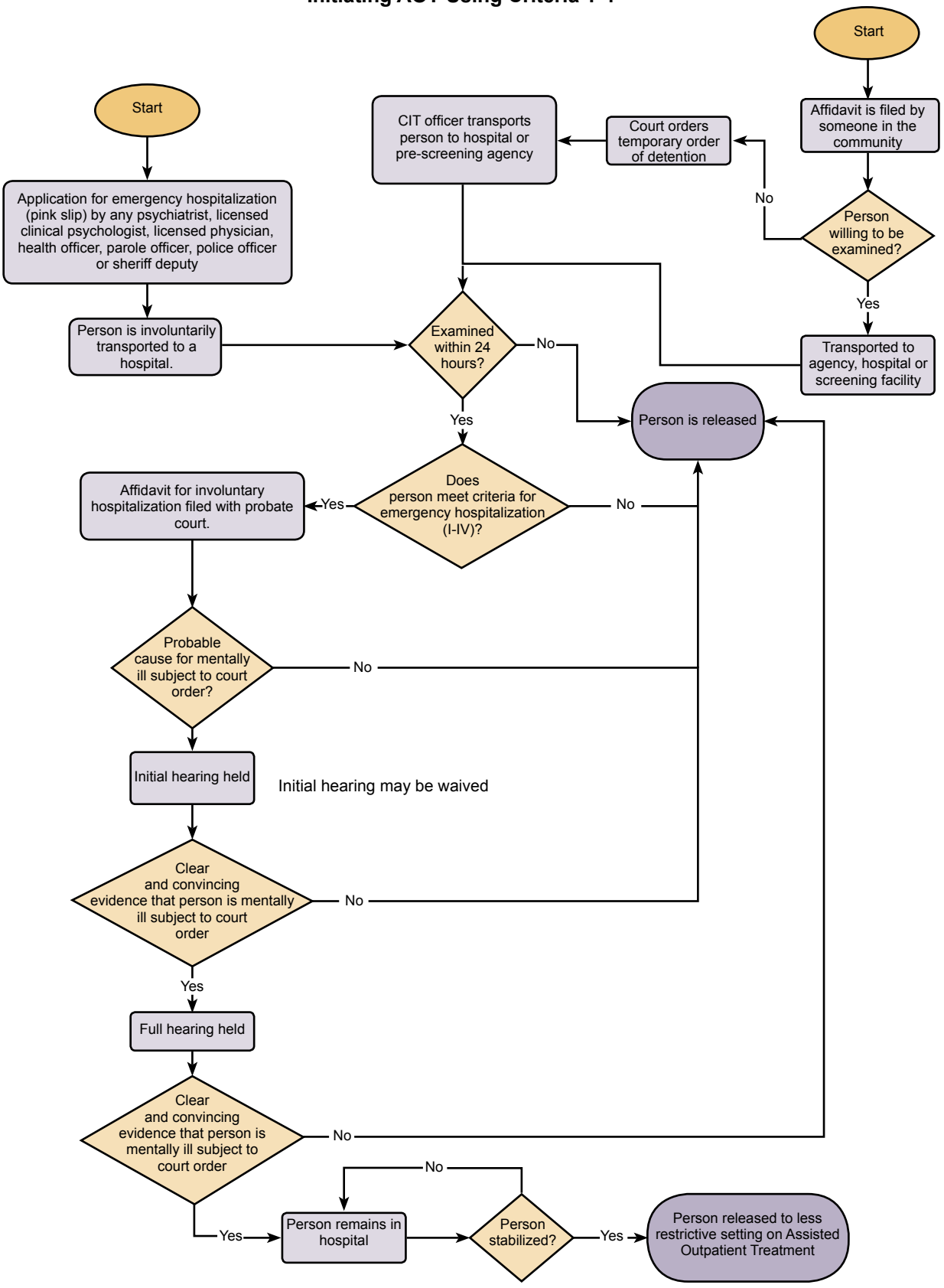
meets the fifth criterion by virtue of his treatment history and the nature of his mental illness, the law establishes a process (described below) by which the individual may be brought before the court and placed under AOT before fully decompensating, thereby averting another psychiatric crisis. This is a sensible use of the fifth criterion in any case where such an individual comes to the attention of the ADAMH Board.

In addition to this use of the fifth criterion to provide AOT in lieu of hospitalization, the fifth criterion might also prove useful in some counties for providing post-hospitalization AOT to qualifying patients. Some ADAMH Boards and/or courts may be uncomfortable with the procedure described above for using the first four criteria to impose AOT after hospital commitment upon a patient who, by definition, still presents a risk of harm. Where AOT has never been practiced under the longstanding Ohio law, the operating premise of the Board and/or judge may be that it is never appropriate to place a patient in the community who still presents a current risk to self or others. Instead, the thinking may be that release should not occur until the patient is stabilized to the point that the risk of harm has been eliminated (at least for the time being). Where such thinking prevails, the fifth criterion may be employed to impose an entirely new commitment – replacing the prior hospital commitment – just prior to or shortly after discharge of the patient. Under this approach to AOT, the Board would seek outpatient commitment on the basis of the patient's mental illness and history of treatment non-adherence, irrespective of any current risk of harm to self or others.

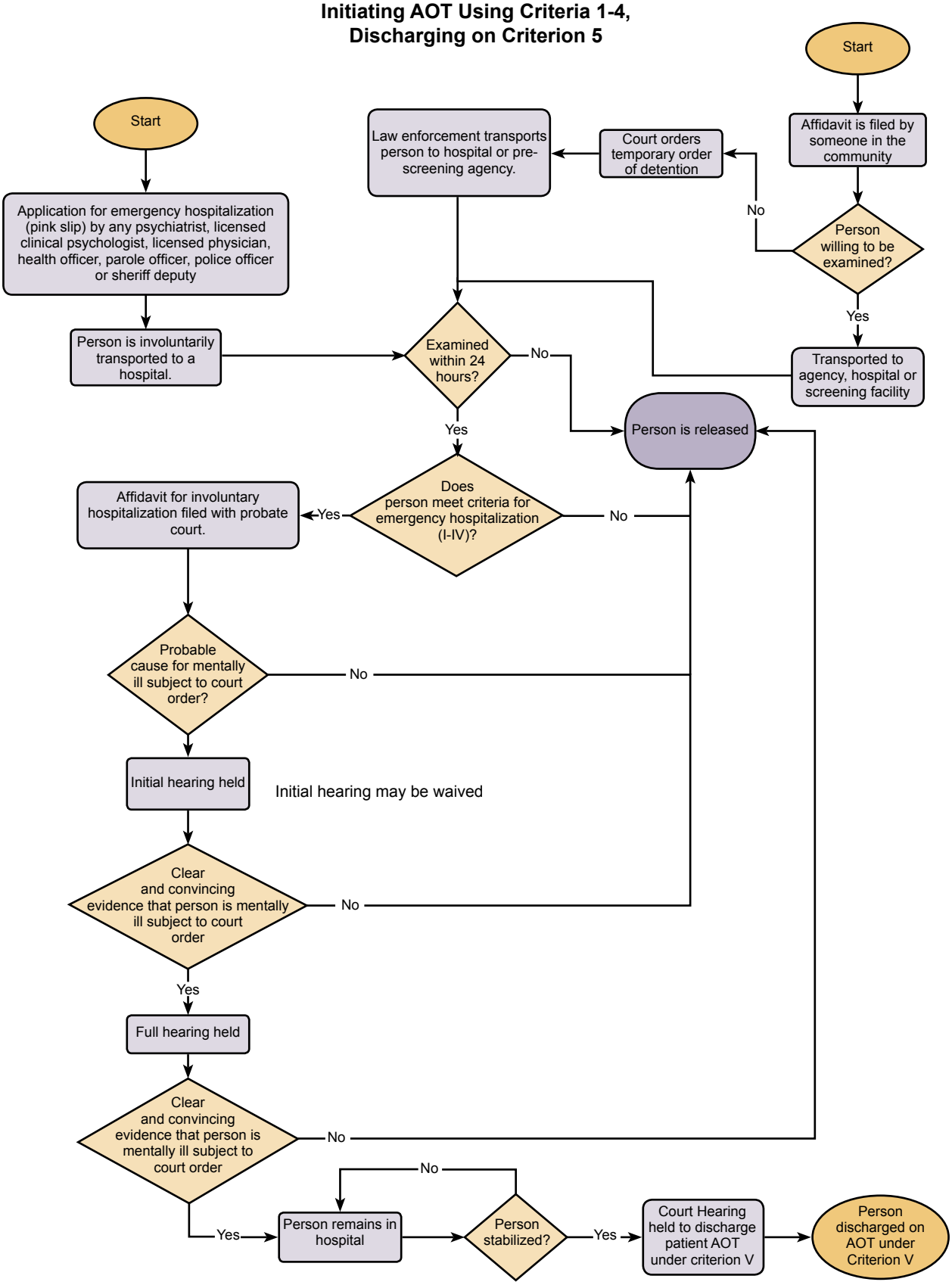
The availability of the fifth criterion can also be helpful in providing AOT to a patient who has been persuaded to accept hospital care voluntarily and never placed under hospital commitment in the first place. Such a patient who meets the fifth criterion at discharge can be released from the hospital directly onto an AOT order.

A drawback of using the fifth criterion to discharge a hospital patient to AOT, rather than continuing a prior commitment under one of the first four criteria, is that if the patient is later found to be non-adherent with the treatment order and in need of return to the hospital, there is no currently pending hospital commitment order to authorize such hospitalization. Accordingly, re-hospitalizing a non-adherent fifth-criterion AOT patient will require specific court authorization based on a new finding that the patient has come to meet one of the first four criteria. (See “Treatment Adherence" below for the two potential processes to accomplish this.)

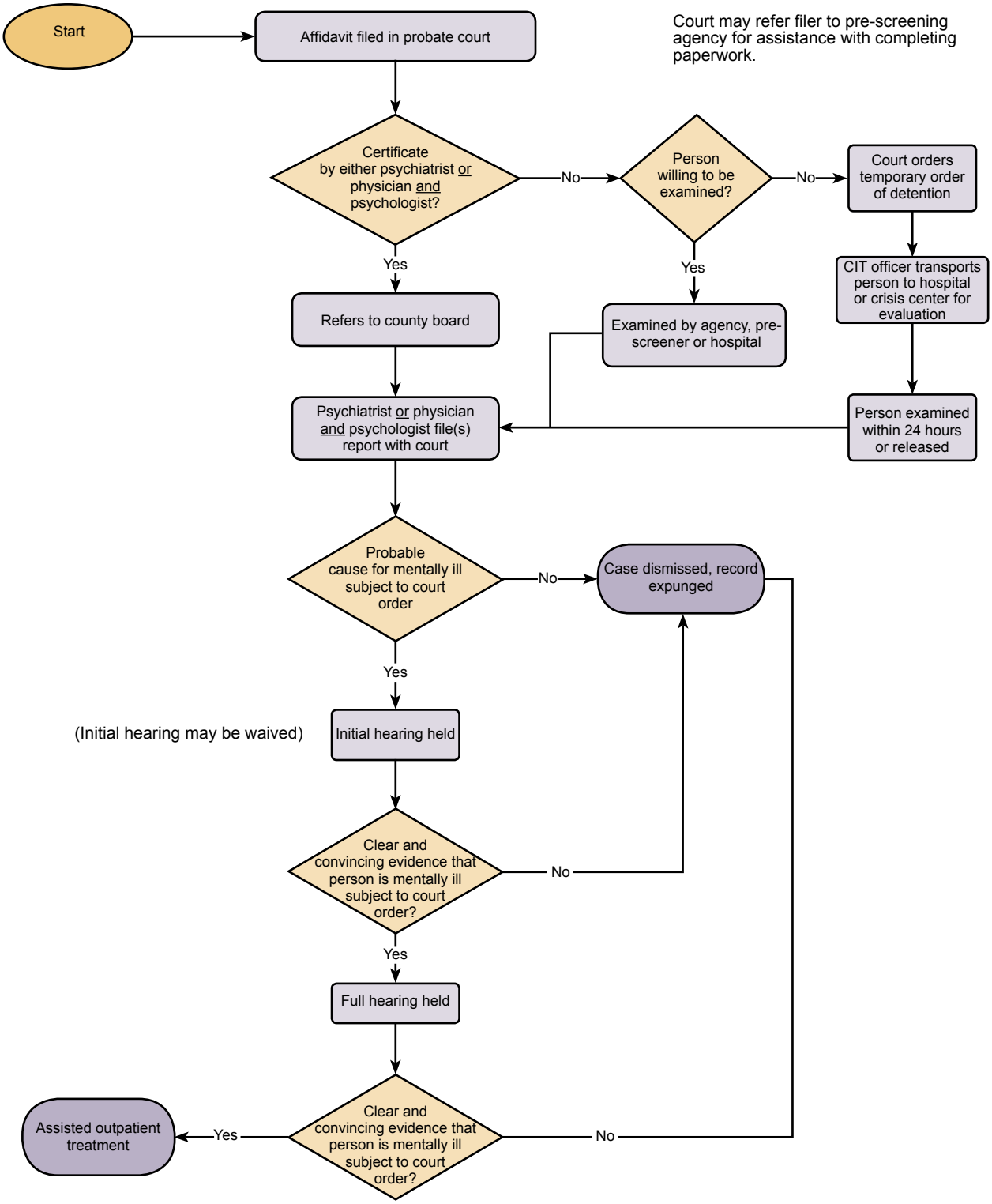
Initiating AOT Using Criteria 1-4



Initiating AOT Using Criteria 1-4, Discharging on Criterion 5



Initiating AOT For Person Currently in Community, Using Any of the 5 Criteria



Obtaining the AOT Order

Initiation

To initiate any commitment proceeding, an affidavit must be accompanied by a certificate signed by a psychiatrist or certificates signed by a licensed clinical psychologist and a licensed physician stating that the person has been examined and is believed to be a "mentally ill person subject to court order." If a certificate is not available, the court may allow the individual filing the affidavit to provide a written statement, under oath, that the person has refused to submit to such an examination.

In either case, the affidavit must be filed with the probate court and there may be a filing fee of $25. The court may waive the filing fee.

Investigation

The court has two business days to refer the case to the Board or a provider designated by the Board to complete an investigation to determine if the person is a "mentally ill person subject to court order" **and** whether appropriate treatment alternatives exist. The resulting investigation and report must be made to the court "promptly."

The report can be in writing, in open court or in chambers. The court keeps a full record of the report, but it is not admissible as evidence in determining whether the individual is a "mentally ill person subject to court order." This report is made available to the person's legal counsel.

Filing an Affidavit: In some counties, the court may refer an individual wishing to file an affidavit to the mental health agency which is designated to assess appropriateness for admission to a state psychiatric hospital. In this scenario a person wishing to file an affidavit in the community is referred to the community agency which serves as the entity investigating possible probate affidavits for the probate court. In some communities the mental health professionals serving in this role are deputized as clerks of the court. The probate investigator meets with the potential affiant and reviews the situation.

1. The investigator explores whether there is probably cause that the person, as a result of mental illness, meets criteria for court ordered treatment. The investigation may include an outreach visit with the potential subject of the affidavit (i.e., patient). The results of the investigation must be reported to the court "promptly," but no time frame is set. The report can be in writing, in open court or in chambers. The court keeps a full record of the report, but it is not admissible as evidence in determining whether the individual is a "mentally ill person subject to court order." This report is made available to the individual's legal counsel.
2. The investigator explores whether the situation is emergent and requires immediate action, which could include a call to law enforcement or an outreach visit by an investigator empowered to initiate a pink slip (most commonly as a designated health officer).
3. The investigator also explores whether the subject might be appropriate for a less restrictive alternative intervention than court ordered treatment. This could include voluntary inpatient or outpatient treatment.
4. If the investigator concludes there is probable cause to file an affidavit, the investigator determines if the person meets the criteria for inpatient and/or outpatient treatment (criteria 1-4) or criteria only for outpatient treatment (criteria 5).
5. If the person is believed to require inpatient hospitalization the affidavit will be filed and the court will issue a temporary order of detention (TOD).
6. Typically, as the court's law enforcement entity, a sheriff's deputy will receive the TOD and facilitate transport to the hospital or pre-screening agency.
7. For the person who has refused an examination the court may appoint a psychiatrist or clinical psychologist/physician to conduct an examination and report to the court the person's need for custody, care or treatment in a hospital. A written report may be accepted as evidence by the court.

Temporary Order of Detention/Transport to Hospital

If, as a result of the investigation, the court believes there is probable cause that the person is a "mentally ill person subject to court order," the judge or magistrate may issue an order of temporary detention. This would result in the law enforcement officer taking the person into custody and transferring him or her to a hospital or other facility able to provide an evaluation. The court that issues such an order retains jurisdiction in the case, even if the person is transported outside of the county.

If the transport is to a hospital emergency department, crisis center or other pre-screening facility, a psychiatrist or licensed psychologist/physician will examine the person to determine whether hospitalization is needed.

Hearing Process

If the person is not hospitalized but it is believed the person meets criteria for AOT, a report can be made to the court and a hearing can be scheduled.

If it is determined that inpatient hospitalization is appropriate, the person will be admitted to an appropriate inpatient psychiatric unit. Once hospitalized the person must be afforded a hearing. The person has the right to counsel, which shall be provided by the court if the person cannot afford one. The hearing must be conducted within 5 court days from the day in which the person was detained or when the affidavit was filed, whichever is sooner. This hearing is to be conducted in a setting not likely to have a harmful effect on the person and may be conducted in a hospital in or out of the county in which the affidavit was filed. The Court must send a notice of the hearing to:

- The respondent (person)
- Legal guardian, spouse, or parents in the case of a minor
- Person who filed the affidavit
- Any person designated by respondent or next of kin if possible
- Person's counsel
- Hospital director, CCO or designee
- ADAMH Board serving person's county or residence

The court can order a continuance of the hearing for no more than 10 days from the day the individual was detained or when the affidavit was filed, whichever is sooner. If the hearing is not held within the required time frame, the person must be discharged from the hospital.

The statute says that whenever possible the initial hearing shall be held before the person is taken into custody. As we shall see, this is mandatory for hearings that are held based on the fifth criterion in the definition of "mentally ill person subject to court order." If the person meets one or more of the first four criteria, waiting for a court hearing is not likely to be considered safe for the person. However, there may be exceptions where hearings can appropriately precede hospital admission.

The statute also says that the initial hearing may be waived by the person or counsel with the person's consent. Should that happen, a full hearing must be held within 30 days after the initial detention of the person. In most counties initial hearings are routinely waived and a full hearing is held immediately at the time of the initial hearing. Given very short hospital lengths of stay and the desire to begin treatment as quickly as possible, the value of an initial hearing in most cases is unclear. There may be situations where a discharge without the need for ongoing court ordered treatment is anticipated. In those cases, a person could avoid the experience of a hearing. But for cases in which ongoing court ordered treatment is likely to be recommended, waiving of the initial hearing and moving to a full hearing rapidly is recommended practice.

> *[For] cases in which ongoing court ordered treatment is likely to be recommended, waiving of the initial hearing and moving to a full hearing rapidly is recommended practice.*

Whether an initial or a full hearing, the hearing is conducted by a judge or magistrate. It may be conducted in a hospital, which is preferred to minimize safety risks and facilitate availability of testimony by treating psychiatrists.

> *[The hearing] may be conducted in a hospital, which is preferred to minimize safety risks and facilitate availability of testimony by treating psychiatrists.*

These hearings are generally closed to the public. The person has the right to attend the hearing, be represented by counsel, and be informed of the right to have an independent expert evaluation. The court is required to pay for an independent expert evaluation if it is requested and the person is indigent. Some counties routinely provide an independent evaluation at court expense, whether requested or not. In most counties the independent evaluation is only offered if

Testimony by Treating Psychiatrists: In most counties in Ohio, the treating psychiatrist in the hospital is typically the provider of the testimony in support of the application for commitment. At first glance, this may seem to contravene In re Miller, 63 Ohio St.3d 99 (1992), an Ohio Supreme Court Case which held that testimony provided in support of commitment by the appellant's longtime psychiatrist violated Ohio's statutory privilege for certain communications between a patient and his or her physician. O.R.C. Ann. § 2317.02(B)(1). In deference to the Miller ruling, some Ohio counties have adopted a standard practice of using an independent psychiatrist to examine the individual and provide the testimony in support of the application.

While the use of an independent psychiatrist is indeed what the court in Miller endorsed as "the best procedure," it should also be noted that the court did not go so far as to categorically prohibit testimony by a treating psychiatrist in support of a commitment application. Rather, the court ruled that the testimony given by the treating psychiatrist in the particular case at issue was inadmissible, because the testimony had revealed patient-physician communications which had occurred over the psychiatrist's entire ten-year relationship with his patient. The court acknowledged that it might have reached a different result had the treating psychiatrist's testimony "been limited to the facts he became aware of during the course of examining appellant for this commitment only."

This distinction drawn by the court should provide comfort and direction to the many Ohio counties where the pool of available psychiatrists is limited and the "best procedure" of employing independent psychiatrists is impractical. Commitment hearings will not run afoul of In re Miller, so long as the treating psychiatrist who testifies in support of commitment avoids revealing any communications with the patient other than those made during the pre-hearing examination.

It is also important to note that the Ohio law prohibits only the disclosure of certain communications between physician and patient. It does not pertain to information that the physician may have gleaned in the course of treating the patient from a source other than a direct communication with the patient. For example, there would be no Miller issue raised if a longtime treating psychiatrist were to testify at a "fifth criterion" AOT hearing about his patient's history of treatment non-adherence necessitating two hospitalizations of the patient in the prior 36 months, so long as privileged communications were not revealed in the testimony.

requested and rarely is in conflict with the opinion of the treating psychiatrist.

The individual who filed the affidavit is subject to be subpoenaed to appear at the hearing by either party in the hearing. The ADAMH Board designates an attorney to present the case demonstrating that the person is a "mentally ill person subject to court order."

The attorney presenting the case must offer evidence of the diagnosis, prognosis, record of any treatment and plans for care in a less restrictive setting, if there are such plans. The person has the right to cross examine the Board's witnesses and to subpoena witnesses on his or her behalf. The court must find by clear and convincing evidence that the person is a "mentally ill person subject to court order" or order an immediate discharge of the person from the hospital.

Medication Over Objection: For individuals who are thought to lack the capacity to refuse or accept psychiatric medication and who are actively refusing such treatment, a hearing may be held to determine if the court should authorize the administration of medication over objection. Such a hearing may only be held after a person has been found to meet criteria for court ordered treatment and is hospitalized. Ideally the hearing to determine capacity to refuse treatment can be scheduled to immediately follow the civil commitment hearing, so that patients do not have to languish in the hospital untreated any longer than necessary. This may be a compelling reason to waive an initial hearing and move directly to a full hearing. While the statute is not clear, many courts believe that the treatment over objection hearing can only occur after a full hearing, not an initial hearing.

If the court finds by clear and convincing evidence that the person is a "mentally ill person subject to court order," it may commit the person for up to 90 days to one of six possible places or people:

- A state-operated psychiatric hospital.
- A non-public hospital
- The Veteran's Administration or other agency of the U.S. government
- An ADAMH Board or an agency the Board designates
- Private psychiatric or psychological care and treatment
- Any other facility or person that is suitable under the circumstances. (This cannot be a correctional facility.)

Most often, the person is committed to the ADAMH Board of his county of residence. It is also common for a person to be committed to a hospital located outside the county of residence, in which case jurisdiction may need to be transferred to the home-county Board upon hospital discharge. Committing a person to the Board assures flexibility in placing that person in the most appropriate, least restrictive setting. It facilitates hospital discharge and community monitoring upon discharge. It is recommended that absent exceptional circumstances courts commit individuals to the ADAMH Board of the county of residence.

> *It is recommended that absent exceptional circumstances courts commit individuals to the ADAMH Board of the county of residence.*

At the time of the court hearing for commitment under one of the first four criteria, the treating psychiatrist will typically recommend to the court whether the commitment order should remain in place after hospital discharge. In other words, a decision could be made at this time whether eventual AOT is indicated for the patient. But, as discussed above, some courts or ADAMH Boards may not be comfortable using the same criteria for inpatient and outpatient commitment. In such jurisdictions, an AOT-specific hearing may be scheduled just prior to discharge from the hospital. At this hearing the Board's attorney would present a case to the court that the patient meets the fifth criterion and should be court-ordered to AOT only.

Geller's Clinical Guidelines: In the 1990s, the psychiatrist Jeffrey Geller published clinical guidelines to determine the appropriateness of using what today we call AOT. While some of these guidelines relate to the treatment system, others describe the individual for whom AOT is most appropriate. These guidelines remain a helpful description of what is commonly referred to as a "revolving door patient," for whom AOT is most appropriate. There are likely a smaller number of individuals appropriate for AOT who are earlier in their course of illness, so don't meet the history criteria of Dr. Geller, but are thought to be very high-risk. The Geller criteria include:

- The patient must express an interest in living in the community.
- The patient must have previously failed in the community.
- The patient must have that degree of competency necessary to understand the stipulations of his involuntary community treatment.
- The patient must have the capacity to comply with the involuntary community treatment plan.
- The treatment or treatments being ordered have demonstrated efficacy when used properly by the patient in question.
- The ordered treatment or treatments must be such that they can be delivered by the outpatient system, are sufficient for the patient's needs, and are necessary to sustain community tenure.
- The ordered treatment must be such that it can be monitored by outpatient treatment agencies.
- The outpatient treatment system must be willing to deliver the ordered treatments to the patient and must be willing to participate in enforcing adherence with those treatments.
- The public sector inpatient system must support the outpatient system's participation in the provision of involuntary community treatment.
- The outpatient must not be dangerous when complying with the ordered treatment.

Source: Jeffrey L. Geller. "Clinical guidelines for the use of involuntary outpatient treatment," *Hospital & Community Psychiatry* Vol. 41 Iss. 7 (1990)

There is a divergence of practice among those Ohio counties that typically discharge patients with their original commitment to the Board (under one of the first four criteria) still in place. In some such counties, a courthouse hearing is held within a few days of the discharge for a decision on whether it is appropriate to terminate the court order (freeing the patient from any legal obligation to participate in treatment) or keep the court order in effect until its original expiration date. Other counties see no need for this post-discharge hearing; the default practice instead is to simply inform the patient upon discharge that the initial 90-day commitment remains in effect in the community, obligating the patient to receive AOT. A courthouse hearing does not take place until the original order expires, at which time the Board must recommend and the court must decide whether to renew the commitment or allow the patient to pursue voluntary treatment. The practice of holding a hearing very soon after discharge is recommended, because it allows the patient to receive the benefits of a court hearing -- impressing upon him the vital importance of treatment adherence -- at the beginning of the AOT experience.

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Application for Voluntary Admission

While a person has the right to sign an application to voluntarily admit himself into the hospital, the application does not have to be accepted if it is thought that the person lacks capacity to sign voluntarily or requires ongoing court ordered treatment. If accepted, voluntary admission negates the existing commitment. Needless to say, this would prevent the transfer to AOT as a less restrictive alternative following a successful period of hospital treatment.

However, it would remain possible for the Board to pursue a new application for AOT specifically, at the point of the patient's discharge from voluntary admission. In such cases, an affidavit could be filed to request a hearing to consider AOT under any of the five criteria for civil commitment.

Alternatively, a Board that wishes to pursue AOT following hospital treatment could elect to challenge the application for voluntary admission and seek a flexible commitment under one of the first four criteria. If a Board believes that a patient would benefit from AOT after discharge, it should notify the hospital chief clinical officer before the hospital considers an application for voluntary admission.

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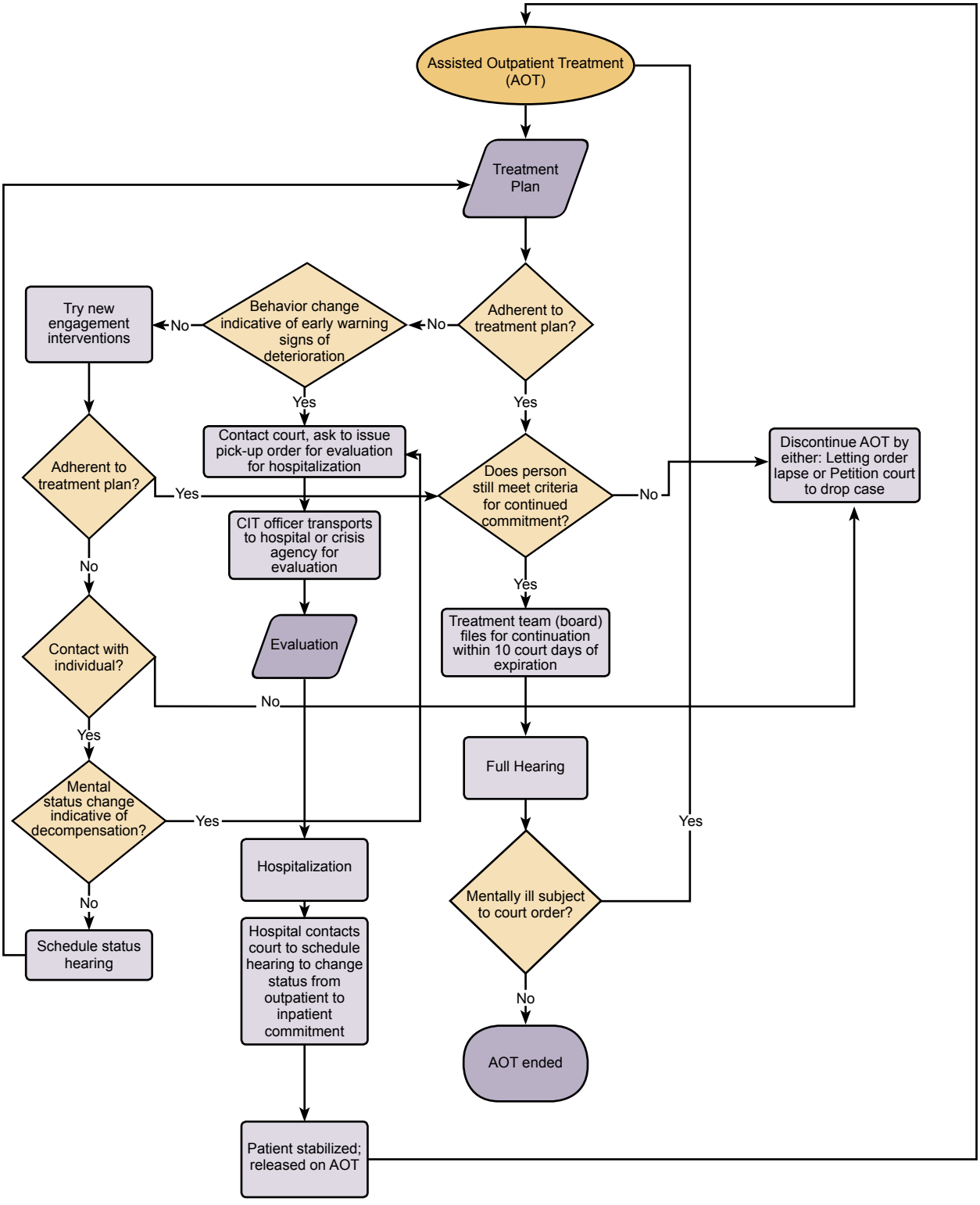
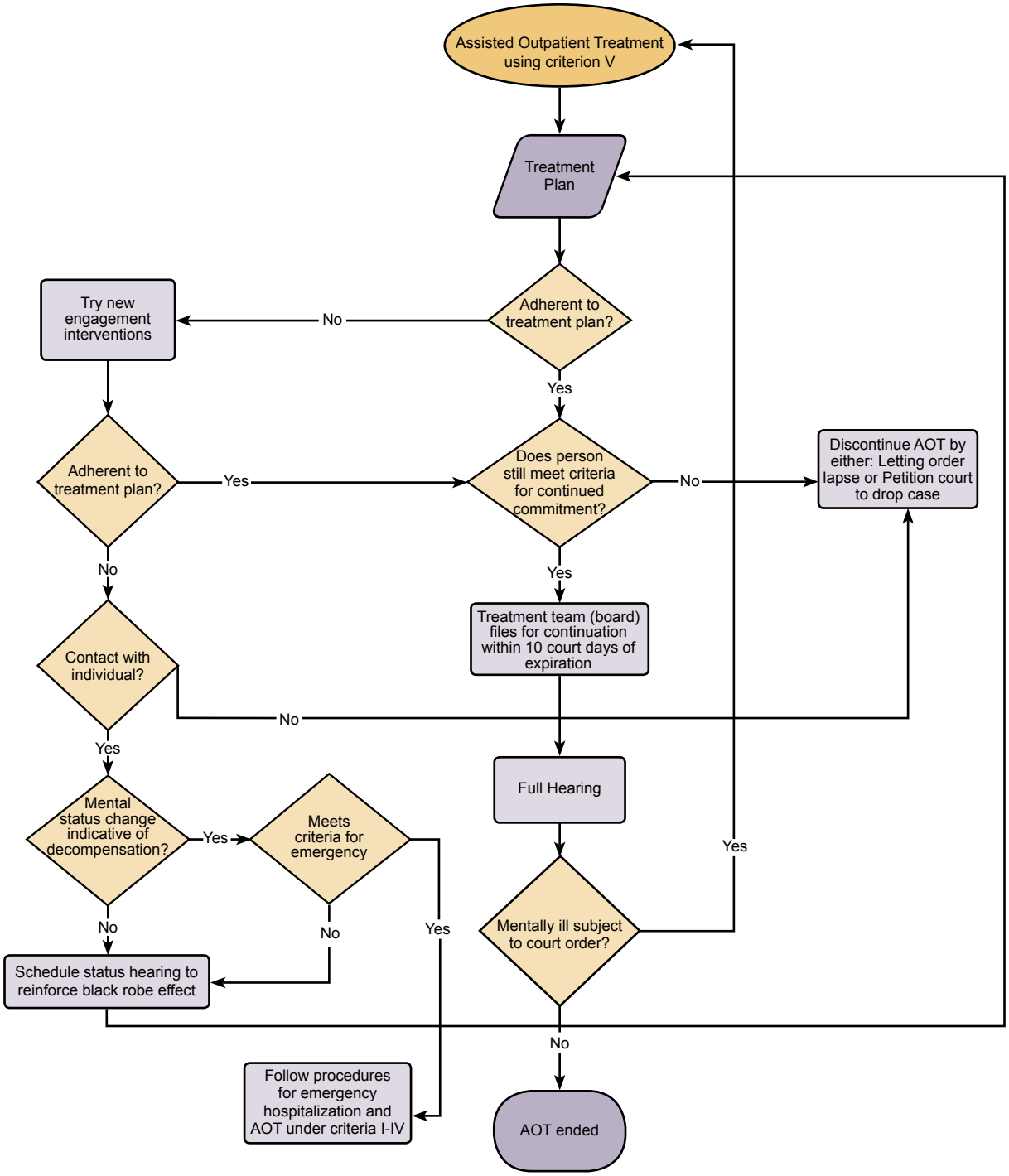
Decision to Request Termination of AOT

Consistent with the discussion above about "voluntary consent for treatment", the decision to ask the court to terminate an AOT order should be made based on consensus by the treatment team that the patient is likely to continue treatment voluntarily after the court order ends. While ideally this would be a result of the patient gaining insight into his or her illness and need for treatment, there are circumstances where the patient has become so engaged in treatment that trust has developed such that the patient will continue treatment because it is recommended by the treating psychiatrist or other member of the team. AOT should not be terminated if the treatment team, Board Chief Clinical Officer or court believes that absent the court order the patient is likely to discontinue treatment.

Carrying Out AOT Using Criteria 1-4



Carrying Out AOT Using Criterion 5 Only



Treatment Planning

In some cases, a patient in a hospital committed to the ADAMH Board is ready to be discharged immediately to an outpatient setting. In that case the AOT process begins immediately upon commitment. More commonly, the patient will need additional time and treatment under hospital care.

The statute requires that a comprehensive treatment plan be established for anyone under a court order (as it would be for any patient). The reality is that the treatment plan in the hospital will focus on the acute care needs of the patient, as well as discharge planning. It is expected that the community treatment team will work with the individual to develop the community treatment plan. While ideally this plan would be fully developed prior to discharge, more likely it will be finalized in the community.

The statute defines a treatment plan as a written statement of reasonable objectives and goals with specific criteria to evaluate progress. It requires documentation of the active participation of the patient in establishing the objectives and goals of the treatment plan. It further states that the establishment of the treatment plan give consideration to the availability of services, and may include, but is not limited to, case management; assertive community treatment; medications; individual or group therapy; peer support services; financial services; housing or supervised living services; alcohol or substance abuse treatment; and any other services to either assist the patient in living and functioning in the community or to help prevent a relapse or a deterioration of the patient's current condition.

Prior to discharge, the community treatment team should engage with the patient and explain the AOT process and program expectations. It is recommended that the ADAMH Board create a standardized document describing the AOT program and outlining all the members of the team and their roles in the process, to be given to the patient prior to discharge into the community.

> *It is recommended that the ADAMH Board create a standardized document describing the AOT program and outlining all the members of the team and their roles in the process, to be given to the patient prior to discharge into the community.*

Every AOT treatment plan, and the intensity of treatment provided, must be tailored to the specific individual needs of the patient served. It is a myth that every patient appropriate for AOT requires service under the highly intensive model known as "Assertive Community Treatment" (ACT). Some patients function at very high levels when on antipsychotic medication; if motivated by the court order to adhere to prescribed medication, they will not require more intensive services. Other patients will require greater community-based support, which may indeed be best achieved through placement with an ACT team.

Monitoring

Every AOT patient requires an assigned case manager with a small enough caseload to allow significant frequent contact with the patient. The case manager must ensure that the patient remains stable and receives care in the least restrictive setting consistent with his needs. The case manager, working with the treating psychiatrist and appropriate other team members, monitors the patient's adherence to treatment and observes for behavior changes similar to previous behavior that preceded a psychiatric decompensation.

When a patient is committed to the ADAMH Board, the Board's Chief Clinical Officer is required to monitor the patient's appropriateness for ongoing court-ordered treatment and to assure that the patient's treatment needs are being met in the least restrictive setting. The CCO may delegate this responsibility to another Board staff member, or to a professional employed by a local Board-supported provider agency or the court. Some AOT programs choose to formalize this delegated role as that of a "probate monitor."

The statute requires the CCO, either directly or by delegation, to examine an AOT patient at least once every 30 days to determine whether the patient continues to meet criteria for court-ordered treatment. Some programs have accomplished this by combining a monthly treatment plan review with a monitoring report, completed by the treatment team for the Board's CCO. Some courts require receipt of regular monitoring reports. An AOT program must maintain a clear understanding as to who is responsible for monitoring each AOT patient, and when and how to take action when warranted.

Treatment Adherence

It is not unusual for an AOT patient to miss one or more scheduled appointments, or even to stop taking prescribed

medication. This alone is not reason to revoke outpatient status. However, if such non-adherence results in a change in behavior, and if that behavior change is consistent with an established pattern of psychiatric decompensation leading predictably to re-hospitalization, the treatment team does not have to wait for a full decompensation to occur.

Before taking significant action to address detected non-adherence, the treatment team should endeavor to assess the patient, either in person in the community, and/or through any collateral information available. If the patient is not clearly demonstrating changes in behavior consistent with his previous signs or symptoms of decompensation, the team should review the case to determine new engagement strategies and modify the treatment plan accordingly.

If more serious measures are deemed warranted, the treatment team's course of action is largely dictated by the type of AOT order in effect.

If the patient is currently committed to AOT under one of the first four criteria, the treatment team may intervene by requesting through the board's attorney that the court issue a temporary order of detention. If ordered by the court, law enforcement (usually the county sheriff, sometimes local police) will go to the patient's residence or known location and bring the patient to a local crisis center, pre-screening agency or hospital emergency department to be evaluated for the need to be re-hospitalized.

Not all individuals evaluated after a temporary order of detention are appropriate for re-hospitalization. Many AOT patients have been prescribed long-acting injectable antipsychotics. If the patient has been late or has missed one or more doses of a long acting antipsychotic medication, he may be willing to resume such medication as an alternative to re-hospitalization. The evaluating physician will need to determine if this is an acceptable option. Crisis centers or hospital emergency departments are encouraged to offer long-acting injectable antipsychotics to patients under such circumstances.

Crisis centers or hospital emergency departments are encouraged to offer long-acting injectable antipsychotics to patients [when deemed medically appropriate].

The decision to re-hospitalize is based on a finding that the patient is in immediate need of hospital treatment because he represents a substantial risk to self or others if permitted to remain in the community. In the case of a patient committed to the Board under one of the first four criteria, it is within the Board's discretion to simply transfer the patient back to the more restrictive setting (hospital).

The Board must communicate such a decision to the court, the Board's attorney and the patient's attorney no later than the next court day. The statute provides that upon request of the re-hospitalized AOT patient, a court hearing shall be scheduled and held within five days of the re-hospitalization. Such a hearing, commonly known as an "out to in" hearing, is scheduled routinely by some AOT programs, even if not requested by the patient. Holding routine "out to in" hearings is a recommended practice.

Holding routine "out to in" hearings is a recommended practice.

If the non-adherent AOT patient is currently committed under the fifth criterion only, the appropriate response depends upon the severity of the patient's current condition.

If it is believed that the fifth-criterion patient may now meet one of the first four commitment criteria, an application for emergency hospitalization, or "pink slip," may be completed by an authorized person and the patient may be transported for evaluation and possible hospitalization. (This is the same process used for individuals in psychiatric crisis who are not under AOT.)

If the situation does not appear to have reached the level of a "pink slip" emergency, but the fifth-criterion AOT patient has either failed to adhere to the treatment plan and/or begun to demonstrate early signs of an established pattern of decompensation, the Board or agency may submit a report to the court describing such failure and requesting that the court schedule a hearing. At the hearing, the Board or agency presents the court with possible appropriate treatment alternatives. If the court determines that all treatment alternatives have been exhausted, the court may discontinue the order. The court cannot impose criminal sanctions or confinement in a jail. The court may only impose a more restrictive setting (hospitalization) if it finds, by clear and convincing evidence, that the patient meets one of the first four commitment criteria.

Continued Commitment

An AOT order may be extended repeatedly beyond the initial 90 days. To request a continued commitment, the Board's attorney must file an application for continued commitment at least ten days before the current commitment expires. The application must contain a written report stating the diagnosis, prognosis, past treatment, a list of alternative treatment settings and plans, and identification of the least restrictive treatment setting consistent with the patient's treatment needs. This report must be filed with the court at least three days before the hearing. The application and report must be provided to the patient's attorney immediately upon filing.

Continuation hearings are considered full hearings and cannot be waived. Some AOT programs hold these hearings at the outpatient community treatment center, for the convenience of psychiatrists who testify and the comfort of patients. On the other hand, the judge may feel that holding hearings at the courthouse enhances the "black robe effect" and increases the likelihood of adherence to treatment.

Often the written report with the signature of the psychiatrist is used in lieu of direct testimony in court. The volume of hearings, the number of needed witnesses and local practice will dictate best practices for each community.

The statute allows continued commitment to be granted for up to two years. A two-year commitment is unusual and only recommended for individuals with very protracted histories of refusing voluntary treatment. It is highly recommended that the court choose commitment intervals of 3, 6 or 12 months depending on the history and specifics of the case.

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Voluntary Consent

The statute requires that if at any time after the initial 90-day period the Board determines that the patient "has demonstrated voluntary consent for treatment," the Board should immediately notify all parties and submit a report to the court, which may lead to the court dismissing the case upon review of the facts.

The term "voluntary consent for treatment" is somewhat open to interpretation. What is more clear is that the statute does not obligate the Board to act upon a patient's mere declaration of willingness to voluntarily consent. Rather, such consent must be "demonstrated," which should be reasonably interpreted to require sustained conduct on the part of the patient. It is highly recommended that before a patient's voluntary consent for treatment is accepted, the treatment team reaches a consensus that the patient has gained sufficient insight of his illness and need for treatment, and is very likely to continue treatment independent of the court order.

It is highly recommended that before a patient's voluntary consent for treatment is accepted, the treatment team reaches a consensus that the patient has gained sufficient insight of his illness and need for treatment, and is very likely to continue treatment independent of the court order.

Q: Can our county implement AOT if we do not have an ACT team in place?

Implementing a successful AOT program requires having the community-based resources it takes to serve individuals with serious mental illness effectively. That said, an "Assertive Community Treatment" (ACT) team is not strictly necessary to implement AOT. A treatment plan should be developed with the patient's specific treatment needs in mind, and should be focused on engagement. It should spell out the specific requirements of adherence that the court will be monitoring, and possible consequences of non-adherence. While case management is a critical component of AOT, not all patients who stand to benefit from AOT require the full range of ACT services. (For example, the Butler and Summit County AOT programs both include ACT in only about 15-20% of AOT treatment plans.) While having ACT in place will certainly enhance an AOT program's ability to meet the needs of more patients, a county unable to offer ACT is certain to find enough patients who do not require such intensive care, and yet can benefit greatly from AOT, to justify making AOT available.

Q: Will AOT disrupt the relationship between patient and provider?

Anecdotally, there is rarely long-term damage to the provider-patient relationship as a result of AOT. While there may be some initial ill feelings, this typically dissipates once the patient has achieved some measure of stability. Evaluation of New York's Kendra's Law has shown that "positive and negative attitudes about treatment during AOT are more strongly influenced by other experiences with mental illness and treatment than by recent experiences with AOT itself." (Swartz, Swanson, Steadmen, Robbins, & Manahan, 2009) Studies show that procedural justice (treating people with dignity and respect; offering people an opportunity to voice their opinions) correlates more highly with perceptions of coercion than legal status. (Lidz et al. "Perceived Coercion in Mental Hospital Admission: Pressures and Process," 1995)

Q: What should the court do if the person filing an affidavit is not able to produce a certificate signed by a licensed physician stating the person meets the definition of "mentally ill person subject to court order" but is able to produce other evidence to demonstrate probable cause?

The statute says that an affidavit shall be accompanied by a certificate by a psychiatrist or a non-psychiatric physician along with a psychologist. However, the statute also gives courts discretion to accept a written statement by the applicant, under oath, that the person has refused to submit to an examination. In such a circumstance, the court can issue a temporary order of detention ordering custody and transport to a hospital or other designated place for evaluation, or the court can order a hearing on the matter.

Q: If there is probable cause to believe the person for whom the affidavit has been filed meets the fifth criterion but the person refuses to be evaluated, may the court order the person to be picked up for the purposes of an evaluation?

Upon receipt of the affidavit, if the court finds probable cause to believe that the person is a "mentally ill person subject to court order," it may order a "temporary order of detention," allowing the person to be taken into custody and transported to a facility (hospital, crisis center, or agency that pre-screens for hospitalization or other appropriate setting) to be examined. The examination must be completed within 24 hours but there is no prescribed form required by the court. The court shall then set the matter for further hearing within ten days of receipt of the affidavit.

Q: If the AOT patient is already working with a private provider, can that provider be ordered to continue treating the patient?

A private provider cannot be ordered by the court to accept a patient for treatment. The only entities required to accept the patient for treatment are a hospital operated by the Ohio Department Mental Health and Addiction Services, an ADAMH Board or a provider designated by the Board. The Board CCO may require the patient to see a psychiatrist at a Board-supported agency.

However, if the patient asks to be treated by a private provider, and that provider is willing to work with the assigned case manager and provide the documentation necessary to ensure treatment adherence, such an arrangement is allowable with the consent of the CCO.

Q: If a patient previously committed to hospital care is deemed to still meet the original commitment criteria, but can now be safely treated in the community with an AOT order, is it necessary to file a new affidavit, or can the patient be placed on AOT under the existing order?

It is not necessary to file a new affidavit, as long as:

1. The original finding of "mentally ill person subject to court order" is active, and
2. The patient was initially court-ordered to the ADAMH Board serving the patient's county of residence.

The law allows for a patient to be discharged to a less restrictive setting without dismissing the current order. If the original order is close to expiration, it is recommended that the order be renewed prior to discharge because there will not be adequate time for the community treatment team to assess and file the paperwork needed for a continuation hearing.

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Q: The law allows a renewal of an initial 90-day commitment order to extend for up to two years. Is it a best practice to place an individual under AOT for such a long period?

When the initial order is extended, continued commitment may be ordered for up to two years. However, it is unusual for a court to do so. Continued commitments of 90, 180 or 365 days are far more common than two-year extensions. For example, the standard practice in Butler County is to extend an order for 180 days. This is not to say that there are not a few individuals who will require AOT for periods of two years or longer. This can still be accomplished by a series of shorter extension periods, rather than a single very long extension. Indeed, 6-month or 1-year extensions are recommended as more consistent with the patient's interest in having his status based on a recent evaluation.

Six-month or 1-year extensions are recommended as more consistent with the patient's interest in having his status based on a recent evaluation.

Q: If an AOT patient is not adherent to outpatient treatment, should we have law enforcement bring him into the agency?

This would not be an appropriate use of law enforcement and risks needless escalation of encounters between police and community members. Instead, the program must develop a policy to address AOT patients who, as a result of non-adherence to treatment, are beginning to show behavior changes consistent with early warning of relapse. In Summit County, a report is faxed to the court requesting a court-ordered evaluation. If the court determines there is probable cause, it will issue a temporary order of detention and a sheriff's deputy will find and transport the patient to the crisis center (pre-screening agency) to determine the need for re-hospitalization. In some jurisdictions city police are used instead of county deputies. In this scenario, the court is taking action at the request of the treatment agency. Neither the court nor the agency is acting on its own.

Q: What is the protocol when an AOT patient moves to another county in Ohio, or out of the state entirely?

If the patient is committed to the ADAMH Board and moves to another Ohio county, the Board should notify both the local court that issued the AOT order and the ADAMH Board in the new county of residence. If there is an AOT program in the new county, the court can transfer the case to the new jurisdiction. If there is not an AOT program in the new county of residence, the court should consider terminating the order once the patient's relocation has been verified. Regardless of whether the court order will continue in the new county of residence, the treating agency, with assistance from the Board, should work with the patient to continue care in the new county. Whenever possible, this should consist of a warm hand-off with intake appointments and continuation of medication secured.

If the patient moves outside Ohio, the AOT order will not be transferable to a local court, regardless of whether the new jurisdiction of residence practices AOT. The Board, court, and treating agency should follow the protocol described above for terminating the order.

Q. What are the best practices for helping AOT patients understand their rights, responsibilities, and reasonable expectations as participants in the program?

The court plays a vital role in communicating rights and responsibilities to AOT patients. In Summit County, newly discharged patients under court order appear in front of the probate judge at New Day Court, where she ensures that all roles are understood and emphasizes the need for adherence

to treatment recommendations. In Butler County, all outpatient continuations are conducted in the magistrate's courtroom. The magistrate is very clear about the patient's responsibilities and the court's role in promoting adherence. Both counties are examples of leveraging the "black robe effect" to encourage adherence to treatment.

A standardized handbook should be given to the AOT patient upon discharge from the hospital or at the time of adjudication in the community.

A standardized handbook should be given to the AOT patient upon discharge from the hospital or at the time of adjudication in the community. The handbook should:

- be written simply;
- provide a basic description of the program;
- assure patients of their right to expect high-quality treatment in conjunction with their responsibilities to adhere;
- list contact information for key members of the program team.

A sample handbook can be found in the appendix.

TreatmentAdvocacyCenter.org
Namiohio.org
Neomed.edu
Mcmfdn.org