OHIO DEPARTMENT OF MENTAL HEALTH

Forensic Strategies Workgroup

Final Report

Presented to:

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Ohio Department of Mental Health

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ACKNOWLEDGEMENT

The number of people with a forensic legal status being served in Ohio's public mental health system has grown since passage of the state's 1988 landmark mental health legislation – the "Mental Health Act." When paired with diminishing mental health resources, the increased number of forensic individuals being served in Ohio's county-based mental health system and state-operated hospitals creates problems for mental health providers, boards, advocates, judicial and law enforcement professionals, clients and families, and others in need.

Ohio's forensic population typically has complex and overlapping mental health and supportive needs; if those needs are not managed promptly and precisely, then negative or untoward outcomes can result. Therefore, clients considered to be "forensic" are usually involved with several agencies and systems that may include judicial/law enforcement, mental health services, income maintenance, health care, etc. We know from experience that 70% or more of forensic individuals with mental illness have alcohol or substance abuse issues which may cause or trigger related problems such as re-offending. Forensic clients may also possess learning or developmental related difficulties that impact their needs, safety, and propensity for re-offending or re-entry into the criminal justice system.

The Forensic Strategies Workgroup engaged in forensic strategy planning from August through December, 2009. During these five short months, the workgroup's monumental task was to study, analyze, evaluate and recommend the most efficient near-term strategies for addressing the growing forensic presence and service needs within Ohio's public mental health system.

The workgroup assumed the arduous and challenging task of developing the most critical, yet most feasible, set of strategies to more effectively and efficiently address the delivery of services to Ohio's forensic population without compromising public or client safety.

The Ohio Department of Mental Health (ODMH) gratefully acknowledges the time commitment and dedication of each member of the Forensic Strategies Workgroup. Its facilitator and support staff are identified within Appendix "A" of the report. In particular, we thank Glenda Johnson and Andrea Garringer for providing the necessary administrative support and document workflow, and Karl Donenwirth for his valuable efforts and expertise with the forensic data sets.

Congratulations to the workgroup for delivering a comprehensive set of strategies that can be used by policy-makers and forensic specialists at the provider, board, county and state levels.

Jim Ignelzi
Deputy Director

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INTRODUCTION

Most states are experiencing growth in the forensic population within their state hospitals and Ohio is no exception. Although there may be varying trends in the specific types of forensic clients admitted, it is clear that the fastest-growing segment is individuals admitted for competency restoration services in order to stand trial for misdemeanor and felony offenses. Mental health clients are frequent presenters to Ohio's court system. For those with lower-level or non-violent misdemeanor offenses, court appearances often result from a lack of or need for mental health treatment. Judges and court personnel often have no other options than to hospitalize incompetent defendant clients who commit misdemeanor offenses.

For those clients who are serious offenders and are in need of competency restoration services or who are found Not Guilty By Reason of Insanity (NGRI), it appears that the best option is hospitalization if the clients' mental status represents a danger to self or others. For serious mental health client offenders, the collaborative relationship between and among the legal and mental health system works well in Ohio to advocate and deliver quality mental health services, community monitoring and reporting requirements to the courts. The system in Ohio is proficient and safe in balancing and providing for clients' mental health needs under legal requirements within the context of good public safety practices.

Since the advent of Ohio's Mental Health Act of 1988, however, few options other than hospitalization are available to defendants found Incompetent to Stand Trial-Restorable (IST-R) for misdemeanor offenses (the small number of agencies with outpatient competency restoration services have low utilization rates due to a number of factors such as transportation issues, acceptance at the court level, non-compliance, etc.).

A provision of Ohio's Mental Health Act of 1988 permitted boards to "delay" by one year the responsibility of assuming the financial risk for inpatient services for NGRI and IST-R clients while ODMH and other stakeholders studied the issue and recommended strategies to manage these commitment categories. Although several action steps recommended by this group were accomplished during the past 19 years, the major recommendation mandating management of these commitment categories by local boards through 408 planning and funding continue to be delayed.

"…if utilization of inpatient days for NGRI and IST-R persons is not controlled, ODMH must hold back more funds from the 408 allocation leaving a smaller portion for allocation and distribution to communities." (*Locally Managed Services for Persons Committed as NGRI or Incompetent to Stand Trial: A Study by the Ohio Department of Mental Health, June 30, 1990)*

As predicted, the expanding commitment of withholding 408 resources due to growth in the volume of inpatient forensic services delivered appears to be limiting or decreasing the resources available for distribution to the community system. The dynamics of the growth in forensic services will also continue to impact access to both hospital and community services, and will affect overall system financing.

During August 2009, ODMH Director Sandra Stephenson established the department's Forensic Strategies Workgroup, comprised of representatives of the system's major stakeholders and affiliated service areas. Its charge was to review, evaluate and recommend necessary changes to the current forensic mental health system.

The group was requested to:

- Study and understand the forensic referral and utilization patterns at the outpatient forensic centers and state hospitals, by region and board levels, and by legal status (e.g., Competency Restoration, NGRI, etc., both delayed and non-delayed legal statuses);

- Review other states' activities and trends, including outpatient and inpatient forensic services and unique or "good practices" including financing models or structures; and

- Make recommendations for improvements to the ODMH Director.

THE CURRENT FORENSIC SYSTEM

Ohio has a variable and complex forensic system which requires coordination of policies, programs and funding between and among ODMH, county alcohol, drug addiction and mental health services (ADAMH)/community mental health (CMH) boards, jails, courts, and community service providers for evaluation and short- and long-term treatment of individuals who may have a serious mental illness and who are involved with the criminal justice system.

The complexity and integration of the mental health and criminal justice systems is demonstrated in the flow chart in Appendix B. This interlinked system has produced some very significant and positive outcomes, including the four detailed below:

- Mental health and court services share the goal of providing people with necessary treatment. With state-provided services, local forensic center evaluations and services, and an array of community mental health and court programming, Ohio is recognized as a leader in forensic mental health service delivery.

- The provision of appropriate clinical care is balanced with the utmost regard for public safety. High profile, high risk clients are handled appropriately and conditional release recidivism is low. (See Appendix D.)

- All service entities value the system and strive to improve areas of service coordination, which has been characterized as a "Best Practice" of the Ohio Forensic System.

- Evaluation and diagnostic service quality remains outstanding despite an increase in volume and costs. Some higher costs have resulted from repeated evaluations for

misdemeanor, repeat offenders. There is also concern regarding the availability of recommended treatment and the decrease in funding for monitoring and community treatment.

When coupled with recent state budget cuts, the continued withholding of 408 funds to pay for inpatient forensic services threatens to weaken both the quality and quantity of all mental health services in Ohio (including forensic care). The workgroup identified several problematic characteristics of the current system, including: funding trends for different commitment statuses; trends relating to repeat misdemeanor offenders; variability in practice, funding and services among courts and ADAMH/CMH boards; state hospital differences in bed days, usage and lengths of stay; workforce staffing levels, training, and liaisons with courts; and the level of partnership and involvement with other state agencies and community forensic service providers.

The workgroup also surveyed 13 other states' mental health authorities regarding their current trends, barriers, solutions and financing of forensic services. The states contacted were Arizona, Connecticut, Illinois, Indiana, Michigan, Missouri, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, South Dakota, and West Virginia. (See Appendix E: "Benchmarking Other States.")

While several states cited Ohio as a model for forensic service delivery, many barriers and challenges faced were similar: the lack of housing, stigma and limited forensic expertise in some regions. However, most states paid directly for inpatient forensic services.

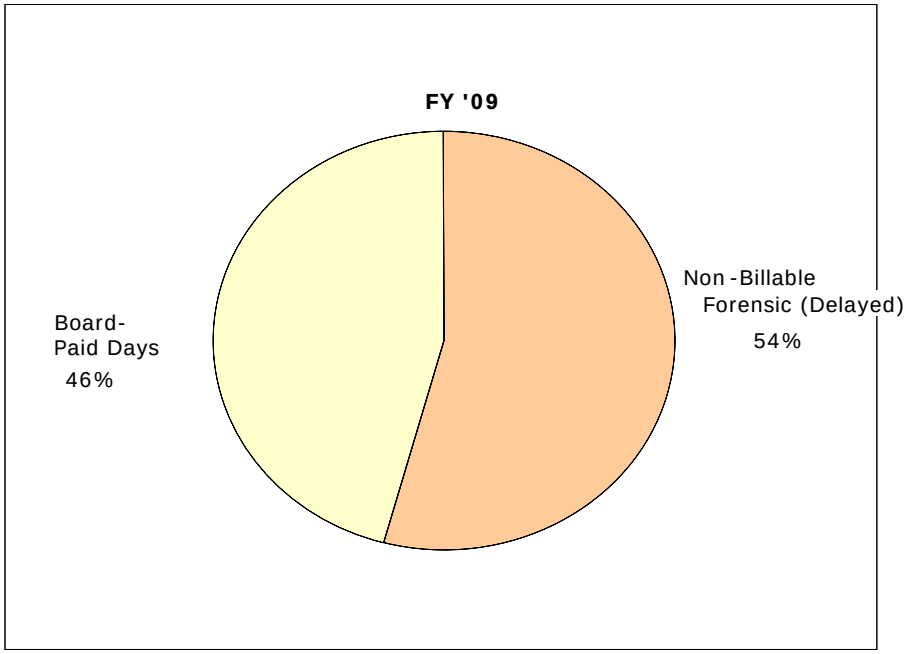
After deliberating monthly since August 2009, the workgroup proposes eight strategies, and related action recommendations that, if undertaken during the next 18 to 24 months, will result in a more financially stable and clinically appropriate forensic services system.

STRATEGIES AND RECOMMENDATIONS

Strategy 1: Establish a new funding mechanism to replace the "delayed" status and strengthen support for increased and separate inpatient forensic and 408 funding.

Since the Mental Health Act of 1988 went into effect, the trends for board-paid and forensic "delayed status" bed days have moved in opposite directions. During Fiscal Year 2009, the "delayed status" bed days (those not billed to boards) exceeded the board-paid days.

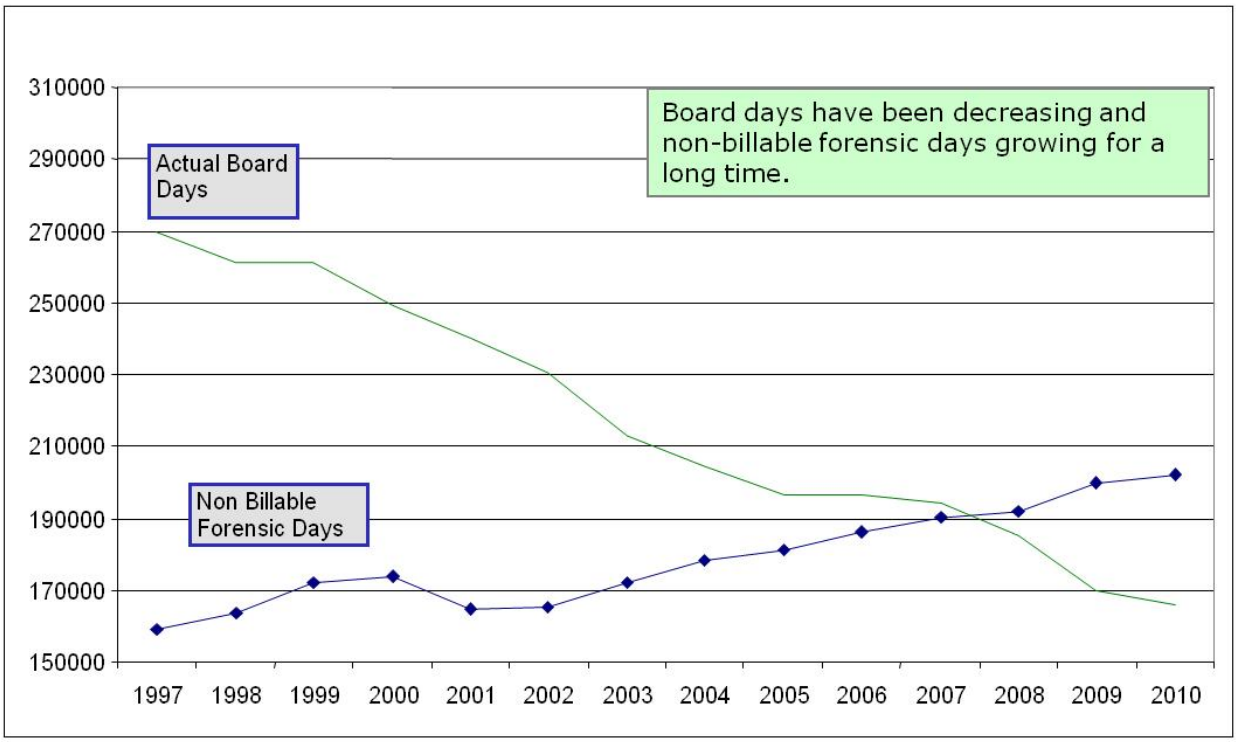
How State Hospital Bed Days Are Typically Divided



NOTE: "Billable Days" means hospital bed days paid by the respective ADAMH/CMH board. "Non-Billable Days" or "Delayed Days" are inpatient days paid by the state.

Trends for board-paid and delayed forensic bed days are also illustrated on the following page. Board bed days have been decreasing for many years, coinciding with the national deinstitutalization movement of the 1960s, the Mental Health Act of 1988, board utilization of private psychiatric beds in general hospitals, etc. In contrast, court-committed delayed bed days have increased, especially during recent years. The growth in forensic days in state hospitals is also part of a national trend.

Hospital Bed Day Trends since FY 1997



The data indicate that the state non-billable days have increased by 2.4% annually since 2001.

The result of these trends, as predicted in the ODMH 1990 report, is that more 408 dollars have been withheld by ODMH for the hospitalization of forensic patients rather than being distributed to boards for community care, including forensic community care.

Therefore, it is recommended that:

> **1.1 ODMH creates a separate state general revenue fund (GRF) forensic services line item for inpatient forensic services. Efficiencies from inpatient forensic care should be utilized as incentive funds for outpatient and innovative forensic community care.**

The current GRF 408 line item in the department's budget consists of three (3) components: 1) 408 Community Flex funds that are distributed to the county boards based upon the boards' Community Plan and the department's distribution formula; 2) Community 408 funds that are withheld by ODMH at the beginning of each fiscal year, at the request of each board, for planned civil inpatient bed days at state hospitals projected in the board's Community Plan; and 3) 408 funds withheld by ODMH for inpatient forensic care at the state

hospitals for individuals committed by Ohio's county criminal courts for competency restoration services or treatment of NGRI (Not Guilty By Reason of Insanity) acquitees and other "long term" forensic legal statuses (see chart below).

The recommendation recognizes that the course of forensic inpatient treatment and the length of stay are largely determined by the interplay between the court and the state hospital as well as patients' clinical response to treatment. The risks associated with forensic patients who have histories of violence are traditionally borne by state authorities responsible for public safety, treatment and associated costs.

The recommendation seeks to create a separate forensic line item in Ohio's budget. The purpose is to resolve the long-standing issue of determining fiscal responsibility and management for inpatient forensic care.

Establishment of a separate line item would hold ODMH responsible and accountable to the Ohio legislature for the allocation and expenditure of funds within that line item. Creation of the line item outside 408 will provide improved opportunities for efficiency and innovation in forensic care which will benefit the entire mental health system.

County ADAMH/CMH boards would continue to be responsible for those inpatient forensic bed days that are currently termed "billable." The grid below depicts the fiscal responsibilities:

Legal Status Code	**Legal Status Description**	**Inpatient cost**
2945.371 G3	Competency Evaluation	COUNTY BOARD
2945.371 G4	Sanity Evaluation	COUNTY BOARD
2945.371 G3/G4	Competency & Sanity Evaluation	COUNTY BOARD
2945.38 A	Competency Maintenance	COUNTY BOARD
2945.38 B	Competency Restoration	ODMH
2945.38 H4/5122.11	ISTU-Probate Court Jurisdiction/Judicial Commitment	COUNTY BOARD
2945.38 H4/5122.141	ISTU-Probate Court Jurisdiction/Probable Cause	COUNTY BOARD
2945.38 H4/5122.15	ISTU-Probate Court Jurisdiction/90-day - 2-year commitment	COUNTY BOARD
2945.38 H4/5122.02	ISTU-Voluntary	COUNTY BOARD
2945.39 A	ISTU- Criminal Court Jurisdiction (CJ)	ODMH
2945.40	NGRI	ODMH
2945.402 A	NGRI- Conditional Release	ODMH
2945.402 A1	ISTU- CJ Conditional Release	ODMH

The intent of this recommendation is to clarify clinical and financial responsibility for forensic inpatient services and to better direct advocacy efforts for increased quality and capacity. It does not generate more financial resources for any sector of the system. The workgroup recognizes the potential for contentious competition for insufficient funds that may be caused by "splitting funding" between the state and community. Developing details regarding community distribution of any state hospital "savings" was beyond the scope of the committee.

1.2 ODMH will strengthen its collaboration, coordination and communication with the Department of Rehabilitation and Correction (DRC) to insure that new programs initiated by DRC and the planned release of inmates by board area are reviewed for any potential mental health service impact, demand, and cost.

New DRC program initiatives with mental health implications and the release of inmates with mental health needs create an increase in demand for local mental health services. Without knowledge of new initiatives or the anticipated number of inmate releases, ADAMH/CMH boards cannot adequately plan for these services.

Strategy 2: Divert non-violent and repeat misdemeanor client offenders who are hospitalized for competency restoration from forensic status to civil hospital or community treatment.

The number of people admitted to the ODMH state hospital system for forensic evaluation, treatment and/or restoration services has been steadily increasing for many years. The department's 1990 report, *"Locally Managed Services for Persons Committed as NGRI or Incompetent to Stand Trial,"* predicted that if certain designed or strategic interventions were not implemented, the mental health system could expect growing numbers of individuals with forensic legal statuses to be admitted to state hospitals.

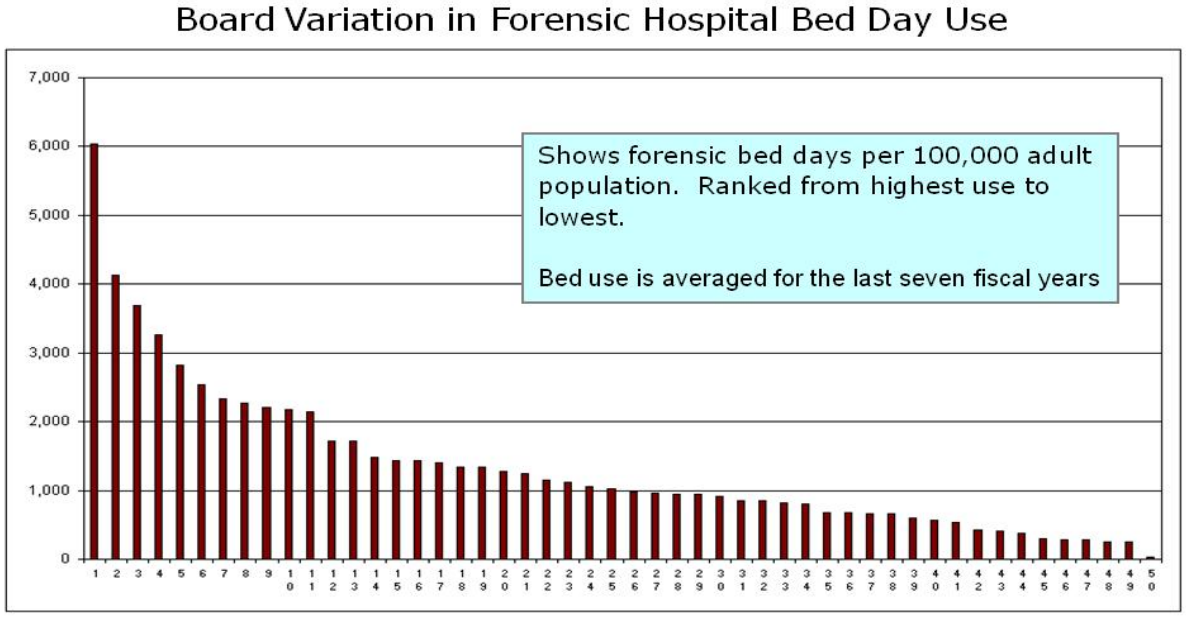
Within this forensic population is a subset of clients that includes one of the largest groups of individuals being admitted to ODMH state hospitals - misdemeanor defendants who are committed for competency restoration services. Within the overall series of recommendations contained in this section, specific diversion interventions deployed at the local court and ADAMH/CMH board level for this group of people could be the single most effective opportunity that may ultimately result in reducing the number of unnecessary hospitalizations for competency restoration clients.

Additionally, we have found that approximately 70% of all hospitalized competency restoration misdemeanor clients experience repeated hospitalizations. Of those, almost 30% (159 clients) have had six or more ODMH hospitalizations.

Competency restoration for defendants typically includes a lengthy forensic process taking from 30 to 60 days (for misdemeanors), to one year for felony cases. Although the inpatient treatment stabilization process to address general psychiatric conditions for misdemeanor clients does not substantially differ from the process for those who are voluntary or civilly committed by the probate court (average of 13 inpatient days), the intensive forensic process and reporting is both time- and cost- consuming. In addition, attempting to restore an individual who is psychotic within 30 days is frequently unsuccessful. We have also found that once the defendant patient is restored to competency and returned to the court for disposition, the original misdemeanor charges are often dropped, making the court and hospitalization process excessively costly. (It is estimated that up to 60% of all misdemeanor charges are dropped after the defendant client is restored to competency and returned to court for disposition).

The large numbers of dropped charges and clients with repeated hospitalizations leads us to believe that for a great many of these client defendants, clinical treatment diversion opportunities (inpatient or outpatient) may be a potential solution to unnecessary and lengthy hospitalizations for competency restoration services.

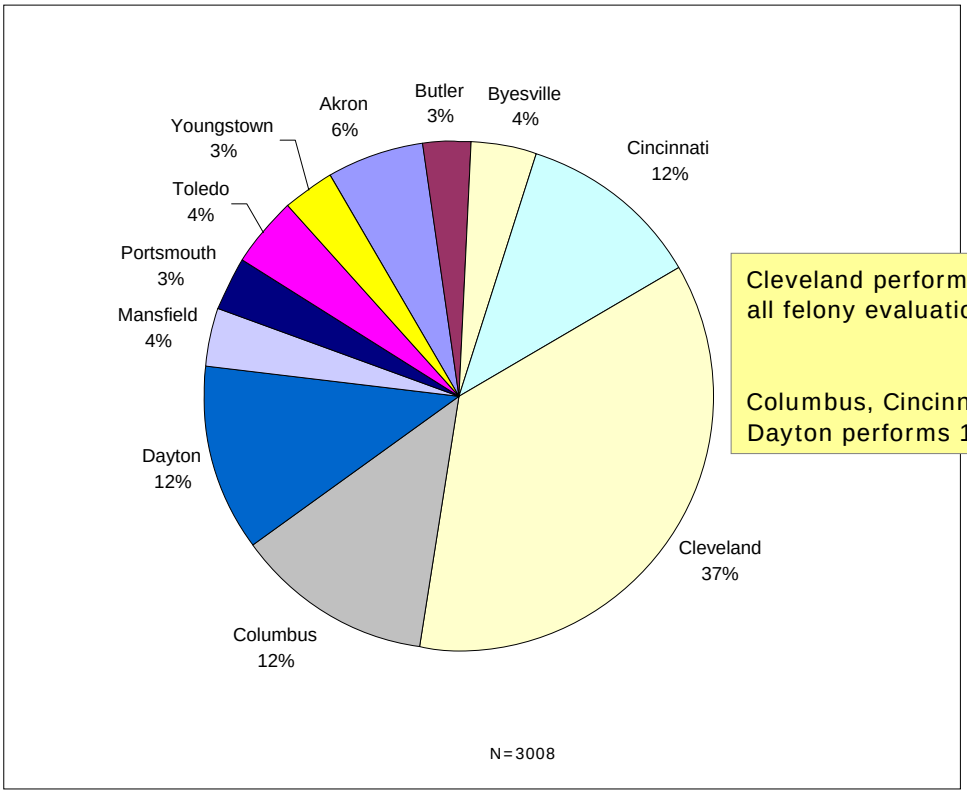
The variability of forensic practices and state hospital usage among Ohio's counties, courts, and hospitals clearly identifies outlier problems. Some variability can be attributed to differing practices among municipal or common pleas courts. Several communities have also established mental health courts, but some appear to function as a means to divert clients from one court to another, while others seem to serve as early identification and case-finding resource for the community mental health system or hospital care. Additionally, courts and the mental health system often hold different and opposing philosophies of compliance and choice, probation and recovery, and expectations of inpatient and outpatient treatment.



KEY:

1 HAMILTON
2 LUCAS
3 MONTGOMERY
4 ASHTABULA
5 CUYAHOGA
6 MAHONING
7 FRANKLIN
8 SUMMIT
9 TUSCARAWAS-CARROLL
10 ATHENS-HOCKING-VINTON
11 STARK
12 BUTLER
13 ERIE-OTTAWA
14 GALLIA-JACKSON-MEIGS
15 WARREN-CLINTON
16 FAIRFIELD
17 WASHINGTON
18 TRUMBULL
19 SCIOTO-ADAMS-LAWRENCE
20 LAKE
21 LICKING-KNOX
22 UNION
23 ASHLAND
24 LORAIN
25 RICHLAND
26 DELAWARE-MORROW
27 ALLEN-AUGLAIZE-HARDIN
28 CLARK-GREEN-MADISON
29 CLERMONT
30 MUSKINGUM
31 HURON
32 BROWN
33 BELMONT-HARRISON-MONROE
34 SENECA-SANDUSKY-WYANDOT
35 COLUMBIANA
36 WOOD
37 ROSS-PICK-PIKE-FAY-HIGH
38 PORTAGE
39 WAYNE-HOLMES
40 VANWERT-MERCER-PAULDING
41 MIAMI-DARKE-SHELBY
42 HANCOCK
43 MEDINA
44 DEFIANCE-FULT-WILL-HENRY
45 PREBLE
46 LOGAN-CHAMPAIGN
47 GEAUGA
48 MARION-CRAWFORD
49 JEFFERSON
50 PUTNAM

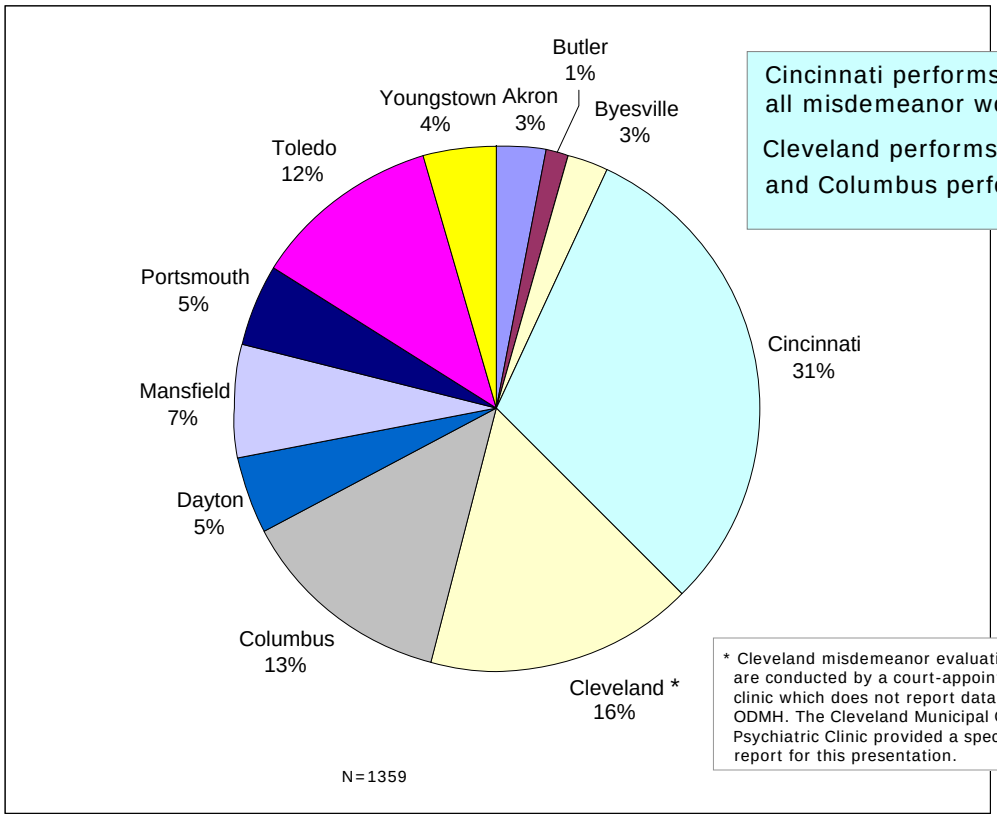
Forensic Center Competency and Sanity Felony Evaluations – FY 2009



Cleveland performs 37% of all felony evaluations

Columbus, Cincinnati and Dayton performs 12%

Forensic Center Misdemeanor Competency and Sanity Evaluations – FY 2009



Cincinnati performs 31% of all misdemeanor work

Cleveland performs 16% and Columbus performs 13%

* Cleveland misdemeanor evaluations are conducted by a court-appointed clinic which does not report data to ODMH. The Cleveland Municipal Court Psychiatric Clinic provided a special report for this presentation.

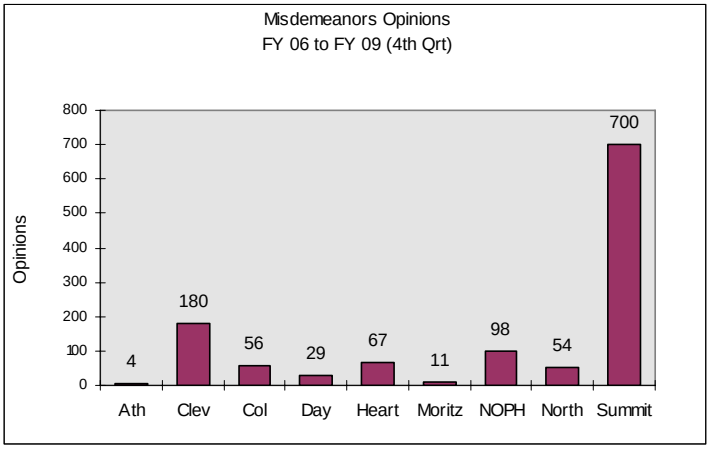
As the data illustrate, the Cleveland Forensic Center performs 37% of all felony evaluations. Since FY 2005, Cleveland's felony evaluations have grown by 57% while the rest of the state has remained relatively static. The Cincinnati Forensic Center accounted for 31% of all misdemeanor evaluations during FY 2009, and has conducted 41% of all misdemeanor evaluations since FY 2005. Furthermore, Summit Behavioral Healthcare comprises 58% of the total misdemeanor cases in state hospitals for the years 2006-09.

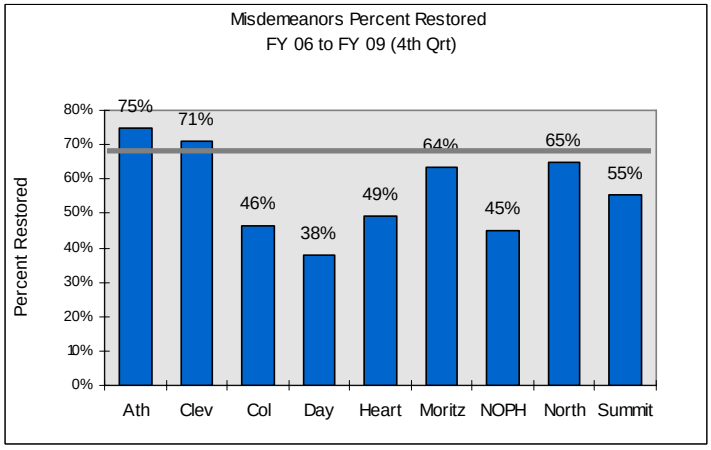
Misdemeanor Totals by Hospital

From FY 06 to FY 09 (4h Quarter)

	Opinions	Restored	Share of Total	% Restored
Athens	4	3	0%	75%
Cleveland	180	128	15%	71%
Columbus	56	26	5%	46%
Dayton	29	11	2%	38%
Heartland	67	33	6%	49%
Moritz	11	7	1%	64%
NOPH	98	44	8%	45%
Northfield	54	35	5%	65%
Summit	700	388	58%	55%
Total	1199	675		56%

Summit, which represents SW Ohio, comprises 58% of total misdemeanor cases.





It is recommended that:

2.1 With agreement of the local prosecutor and court, individuals charged with lower level, non-violent misdemeanor offenses be diverted from the criminal justice system to inpatient (civil probate, emergency or voluntary) or community treatment services, as clinically and legally appropriate. (Charges may be dropped for those clients diverted to community or inpatient treatment with the prosecutor's agreement). (See Appendix C: "Proposed Diversion.")

2.1.1 The Ohio Department of Mental Health and the appropriate state

agencies with jurisdiction create and distribute a joint communication encouraging prosecutors and courts to develop, in conjunction with mental health expertise, processes that redirect appropriate misdemeanor restoration clients to inpatient or community mental health-based clinical treatment and services.

2.1.2. The Ohio Department of Mental Health, working with appropriate judicial parties, develop an educational presentation for diverting and redirecting appropriate restoration misdemeanor clients. This presentation should include examples of programs and processes currently operating in Ohio, and clients who are appropriate for diversion and treatment in lieu of prosecution.

An example of the financial impact this diversion process would have is presented below:

Illustrating the Impact from the Diversion of Misdemeanor Cases
Shows the Potential Impact of Shifting 50% of Misdemeanor Cases to Acute Care Treatment
For Fiscal Year 2009

Restoration to Competency Discharges

	Discharges	Total Bed Days	Total Cost
100% in Restoration Program	206	23,208	$12,184,200

In Comparison . . . If fifty percent of the patients were diverted to acute care treatment without going through the forensic evaluation process.

	Discharges	Total Bed Days	Total Cost
50% in Acute Care Program	103	2,575	$1,351,875
50% in Restoration Program	103	11,604	$6,092,100

Potential Savings in Days	**9,029**
Potential Savings in Dollars	**$4,740,225**

This example scenario illustrates $4,740,225 could have been saved if 50 % of the FY 2009 misdemeanor cases were redirected to acute care inpatient treatment instead of the current forensic misdemeanor process. Substantial more savings could be achieved if clients are

diverted to community mental health care followed with additional community funding. *(Note: this illustration depicts potential inpatient savings from shifting misdemeanor patients to acute care as approved by the local ADAMH/CMH boards or to less restrictive community settings, if appropriate.)* The concept of achieving savings from more efficient inpatient forensic practices and shifting a portion of those savings to boards is described in Strategy 1.1.

2.2 The Ohio Department of Mental Health and respective ADAMH/CMH boards direct special attention to creating diversion processes in Southwest Ohio, (particularly Hamilton County) to reduce unnecessary hospitalization of misdemeanor restoration clients. This should include special consultation or education events, joint meetings with mental health treatment providers and county court personnel and/or prosecutors, and site visits to counties where such diversions are currently in place and working well.

Several Forensic Monitors, Legal Assurance Administrators and court personnel provided examples of efficient practices that occurred with diverting or expediting clients from the hospital, holding the misdemeanor charge in abeyance while treatment was provided. In many cases, the charges were dismissed after restoration was achieved. (See Appendix F: "Forensic Monitor/LAA Best Practices.")

2.3 The Ohio Department of Mental Health initiate the development of statutory change that would require courts and prosecutors to consider diverting appropriate misdemeanor restoration clients to community-based or inpatient civil treatment and services.

Specific statute revisions that would be necessary include:

- Legislative change affecting 2945.371 (G), requiring diversion consideration after the finding of incompetency, and;
- The examiner's recommendation, as contained in (2945.371) (G) (3), add new paragraph (e), shall include the defendant clients' ability to successfully complete a diversion course of treatment, (per the examiner's report).

Cognizant of the financial and workforce capacity issues that this recommendation may raise, the workgroup calls for collaboration on the part of all system components to make changes resulting in more efficient and effective service delivery.

Strategy 3: Create new partnerships and processes for serving special forensic populations that have not traditionally received services or have been underserved.

The mental health forensic service system provides services to many individuals with multiple diagnoses. These people are often characterized as being served inadequately by multiple systems and are frequent presenters to Ohio's court system.

It is recommended that:

3.1 A special task force of the Ohio Department of Mental Health and the Ohio Department of Developmental Disabilities (ODDD), and other stakeholder representatives, be convened to develop collaborative approaches to funding, service delivery and possible court processes for that group of individuals who have traditionally not received services or have been historically underserved.

Typically, these people do not receive services because they do not meet the "severity" criteria of either ODMH or ODDD, or because local services lack the resources to expand services to these individuals.

3.2 ODMH and the Ohio Department of Alcohol and Drug Abuse Services (ODADAS) develop policies and procedures for shared responsibility and funding of inpatient forensic bed days for individuals with a dual diagnosis of mental illness and substance abuse.

Misdemeanor Discharges with a Substance Abuse Diagnosis
For FY 2009

Total Discharges	Substance Abuse Discharges	Percent
206	137	67%

3.3 ODMH and local boards engage in concerted efforts with the State Office of Veterans Affairs, local veterans organizations, Ohio Cares and other stakeholders to create policies and procedures for shared funding and clinical management of community forensic services for veterans.

Strategy 4: Improve the skills and knowledge of the existing forensic services workforce, including appropriate court personnel.

Generally, the forensic workforce is characterized as trained and knowledgeable. However, factors such as staff decreases due to funding cuts and the continuing turnover in the treatment workforce results in erosion of forensic specific skills and expertise. This poses a very real threat to the quality of treatment and coordination of care. Additionally, court personnel and judges are not regularly presented with new information and refresher trainings regarding the forensic process or treatment options.

It is recommended that:

4.1 ODMH, in collaboration with appropriate courts, ADAMH/CMH boards and community providers, create and deliver statewide trainings of forensic service providers and court personnel. These trainings should take advantage of available Internet, video conferencing and computer disc technology.

Many venues currently exist for educational presentations, including new judges' training courses, annual conferences for judges, trainings for regional judges and court personnel, and Bar Association trainings.

4.2 ADAMH/CMH boards encourage assignment of a liaison in each county at the court system administration level to coordinate continued mental health education and communicate new initiatives from the county or state.

4.2.1 ODMH and the appropriate judicial partners develop and distribute a joint communication encouraging ADAMH/CMH boards and local courts to assign such a liaison.

Strategy 5: Strengthen working arrangements with the Supreme Court of Ohio.

The Department of Mental Health and the Supreme Court of Ohio have a rich history of collaboration. The strengthening of this relationship in the future will provide value-added capacity during more challenging times.

It is recommended that:

5.1 ODMH strengthen its coordination, liaison and collaboration with the Supreme Court of Ohio Advisory Committee on Specialized Dockets, the Ohio Judicial Conference and the Advisory Committee on Mental Illness in the Courts to continue discussion of the involvement of the mental health system in its deliberations of mental health courts throughout Ohio.

To the extent possible, representatives of the mental health system should be involved in discussions of all relevant specialty courts.

Strategy 6: Provide increased forensic expertise and consultation to all service areas in the state.

The regional forensic centers possess a specialized body of clinical expertise focusing on assessment of psycho-legal issues, clinical risk assessment, mitigation, and management of clients' risk factors. Local boards and providers should take better advantage of the forensic centers' expertise in the day-to-day management of high-risk clients.

It is recommended that:

6.1 ODMH convene a stakeholder's workgroup to review the scope, role, and funding of forensic centers and Forensic Monitors.

This group should review the current work of ODMH's programmatic review of forensic centers and make recommendations to insure a greater consultation role by forensic centers to local forensic service providers, determine service processes and policies requiring standardization across the state, improve the involvement and interface of forensic centers and monitors with courts and local service providers, and recommend changes for increased and different funding of both centers and monitors.

Strategy 7: Increase the effectiveness and efficiency of the ODMH forensic processes and procedures.

The internal forensic review process varies among ODMH hospitals. The variation also occurs among the regional forensic centers regarding the timing of reports, second opinions and clinical criteria used in recommending patient movement. This lack of standardization can result in delays and inefficiencies.

It is recommended that:

7.1 ODMH, with input from ADAMH/CMH boards and community providers, review and revise its internal forensic processes with the goal of accomplishing the process steps more efficiently, within community safety and risk considerations.

This quality improvement review should include, but not be limited to:

- The length of time for completion and the cost of second opinions with regional forensic centers;
- Streamlining and modifying hospital Forensic Review Team (FRT) policies and processes;
- Standardizing some of the current local practices that seem to improve efficiency while reducing bottlenecks and paperwork involving hospital Legal Assurance Administrators and community Forensic Monitors; and
- Incorporating community input into risk assessments as a way of improving the "hand-off" to community providers.

7.2 ODMH conduct a study of necessary policy and/or state legislative changes needed to effect more efficient forensic inpatient movement from one level to another.

Strategy 8: Increase housing opportunities throughout the state for individuals who have received forensic services.

Hospitalized patients with forensic legal statuses have great difficulty in meeting eligibility requirements for public housing due to criminal background history as NGRI acquitees or

incompetent to stand trial defendants, even though these patients have not been convicted of (alleged) crimes.

It is recommended that:

8.1 The ODMH Content Workgroup: Re-entry and Diversion Committee of the TSIG process or other ODMH body address the barriers to housing opportunities for individuals who have received forensic services, and recommend necessary legislation, approaches and incentives to increase housing opportunities and options for such individuals. Mental Health and court stakeholders, as well as the Ohio Department of Development, should be invited to these deliberations.

8.2 An electronic-based clearinghouse of resources for available housing options should be established by ODMH in partnership with appropriate statewide and county organizations to assist providers in obtaining stable housing for individuals who have received forensic services or who possess a forensic legal status.

Conclusion

The workgroup's vision is the continuing development of a clinically appropriate forensic service system that is effective and efficient for individuals, the state, community service providers, boards and Ohio's court system. Implementation of the strategies and recommendations detailed above will target several areas for this development: clarifying inpatient funding; diverting non-violent offenders to more appropriate civil inpatient commitment or community mental health treatment; increasing and improving collaboration among all stakeholders; increasing workforce skills; and reviewing and revising (if necessary) current policies and procedures. Many of the recommended strategies can be implemented within the next 18 to 24 months; others may take longer but are no less critical. The workgroup also recognizes that some recommended strategies have the potential for unintended consequences and, in those instances, has attempted to explain the intent and concerns.

The successful implementation of these recommendations is Ohio's ability to develop, modify and maintain a high-quality, financially stable mental health system encompassing adequate state and community resources. This is a cornerstone of securing "a sustainable system of care where recovery is expected for people with mental illness and all Ohioans can access quality treatment and supports that are responsive to their cultures, preferences and values" *(ODMH Vision Statement)*.

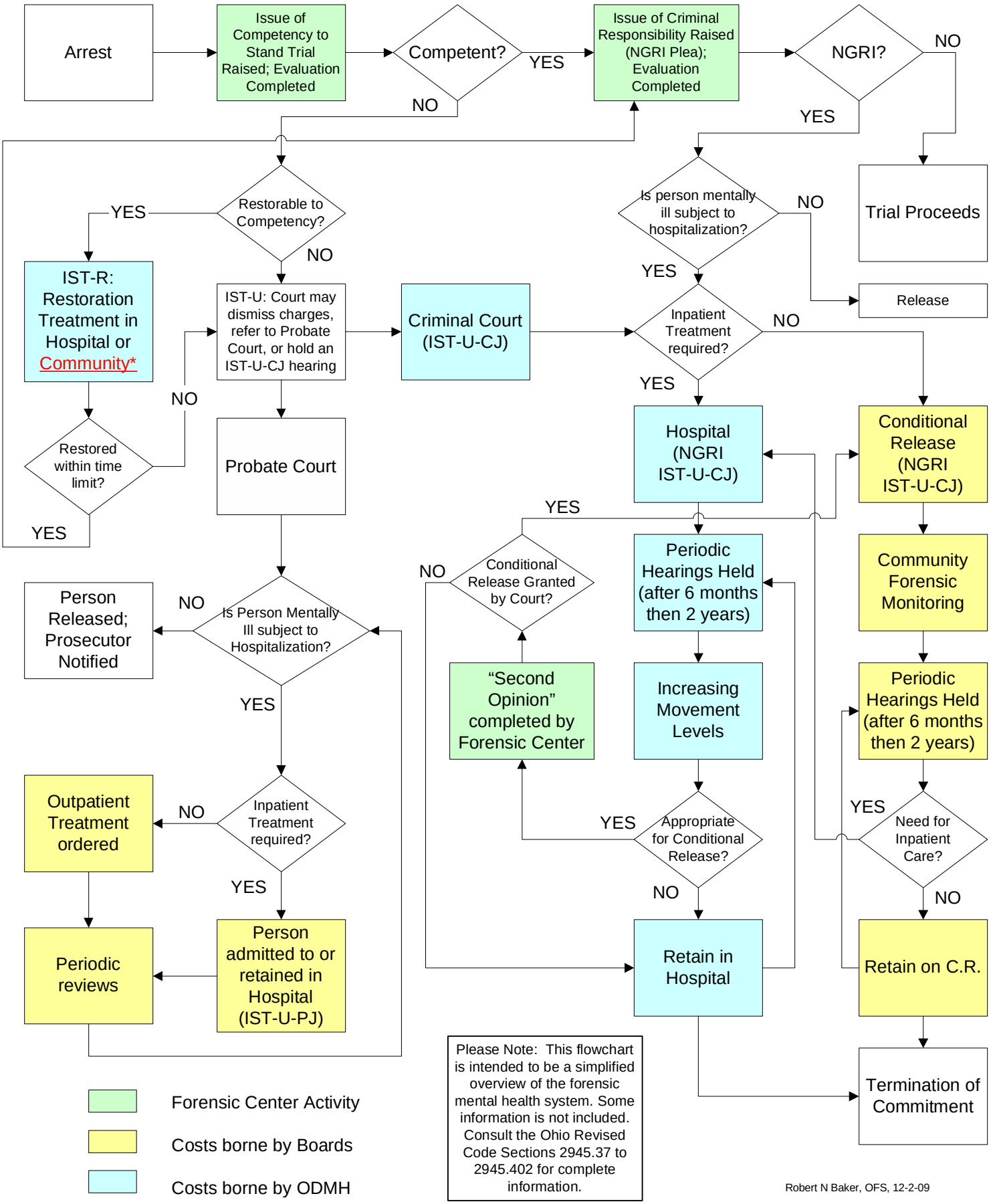
The workgroup thanks Director Stephenson for the opportunity to provide input into the challenges of Ohio's forensic mental health system. We stand ready to assist in future evaluations, reviews or implementation work on any or all of these recommendations.

APPENDICES **Page**

Ohio Department of Mental Health
Forensic Strategies Workgroup
Membership Roster

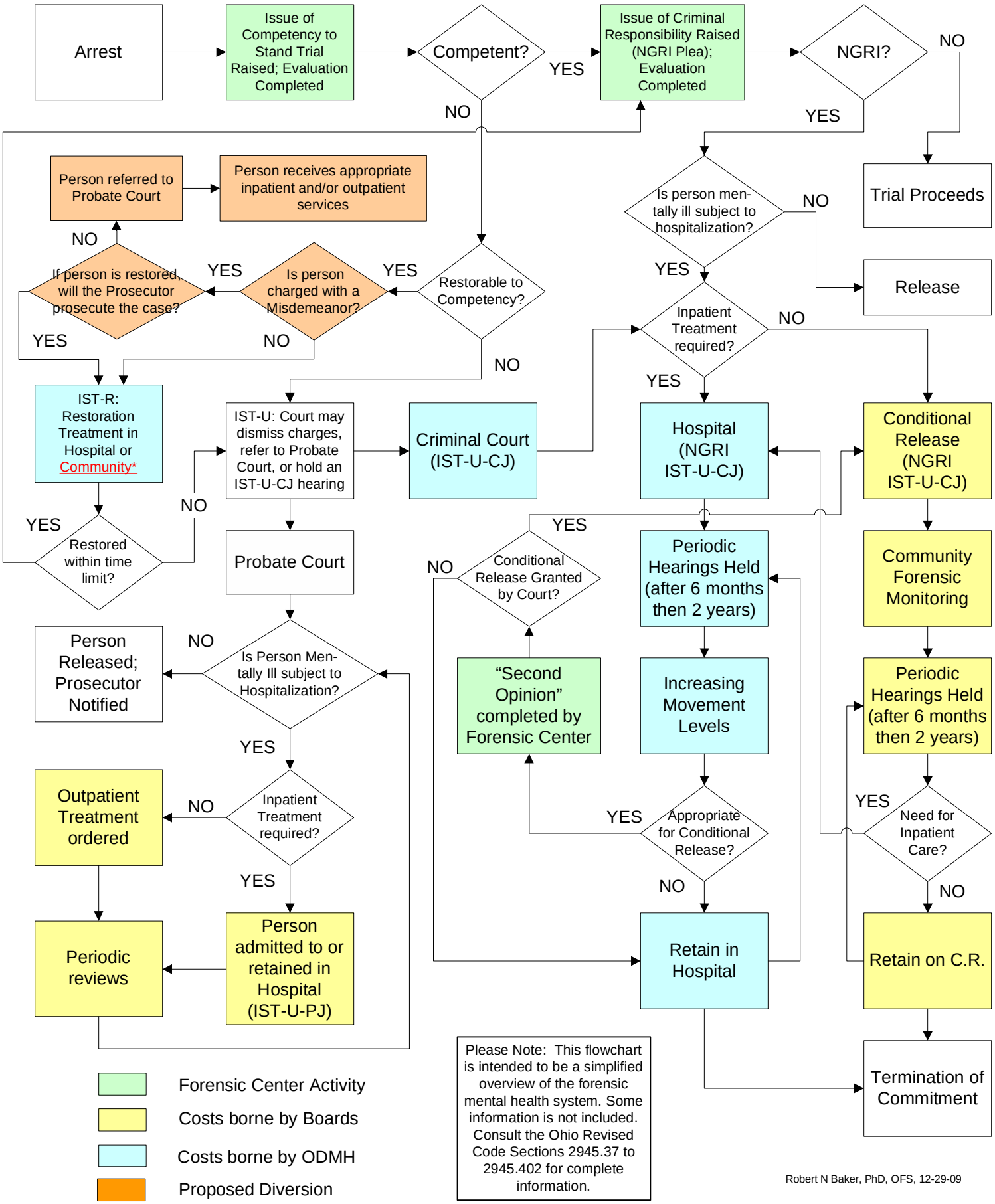
Experts in Forensic Care	Howard Sokolov, MD, Forensic Psychiatrist Kathy Burns, MD, Forensic Psychiatrist; CCO Franklin County ADAMH Board Sandra Cannon, LISW, Former Chief, Office of Forensic Services, ODMH
ODMH Hospital Representatives	Karen Woods-Nyce, LISW, Clinical Director, TVBH Dave Forman, LISW, Legal Assurance Administrator, TVBH Ryan Pierson, MD, Forensic Psychiatrist, Assistant CCO, SBH Thomas Osinowo, MD, Forensic Psychiatrist, CCO NOPH
Ohio Association of Forensic Psychiatric Centers	Terry Kukor, PhD, President
Forensic Monitors	Kara Marciani, PsyD - Allen, Auglaize, Clark, Darke, Greene, Hardin, Madison, Mercer, Miami, Montgomery, Paulding, Preble, Putnam, Shelby and Van Wert Counties Laura Brooks, Recovery Resources Center- Cuyahoga County
Ohio Association of County Behavioral Health Authorities	Cheri L. Walter, Chief Executive Officer Carole Ballard, Forensic Specialist, Cuyahoga County ADAMH Board Karen Scherra, Executive Director, Clermont County ADAMH Board Christina M. Delos Reyes, MD, CCO, Cuyahoga County ADAMH Board
The Ohio Council of Behavioral Health & Family Service Providers	Hubert Wirtz, Chief Executive Officer
NAMI of Ohio	Betsy Johnson
Ohio Empowerment Coalition	David Granger (invited but did not attend)
Ohio Legal Rights	Michael Kirkman, Executive Director (invited but did not attend)
Supreme Court of Ohio	Melissa Knopp, Specialized Docket Section Program Manager
Ohio Judicial Conference	Honorable Pat Harris
Prosecuting Attorneys Association	John E. Murphy, Executive Director
Ohio Public Defenders	Joe Bodenhamer
Recovery Resources	Michael DeHaan, LISW, Program Manager
Eastway Corporation Forensic Psychiatry Center for Western Ohio	Miller Makey, Jr., Director
Ohio Department of Rehabilitation and Correction	Robert Hammond, PhD, Chief Bureau of Mental Health
Ohio Department of Mental Health Central Office	Tereasa Moorman-Jamison, Chief, Office of Forensic Services Bob Baker, PhD, Manager, Community Forensic Programs Debbie Nixon-Hughes, LISW, Deputy Director Jim Ignelzi, Deputy Director Karl Donenwirth, Policy Analysis, Hospital Services Dalon Myricks, Assistant Deputy Director & Chief, Fiscal Administration Theresa Seagraves, Director of Systems Integration Glenda Johnson, Office of Forensic Services Andrea Garringer, Hospital Services
Facilitator	Jeannette Harrison

Overview of Competency and Sanity Processes in Ohio's Forensic Mental Health System
Current System



* Community-Based Restoration is Board financial responsibility

Overview of Competency and Sanity Processes in Ohio's Forensic Mental Health System
Proposed Diversion

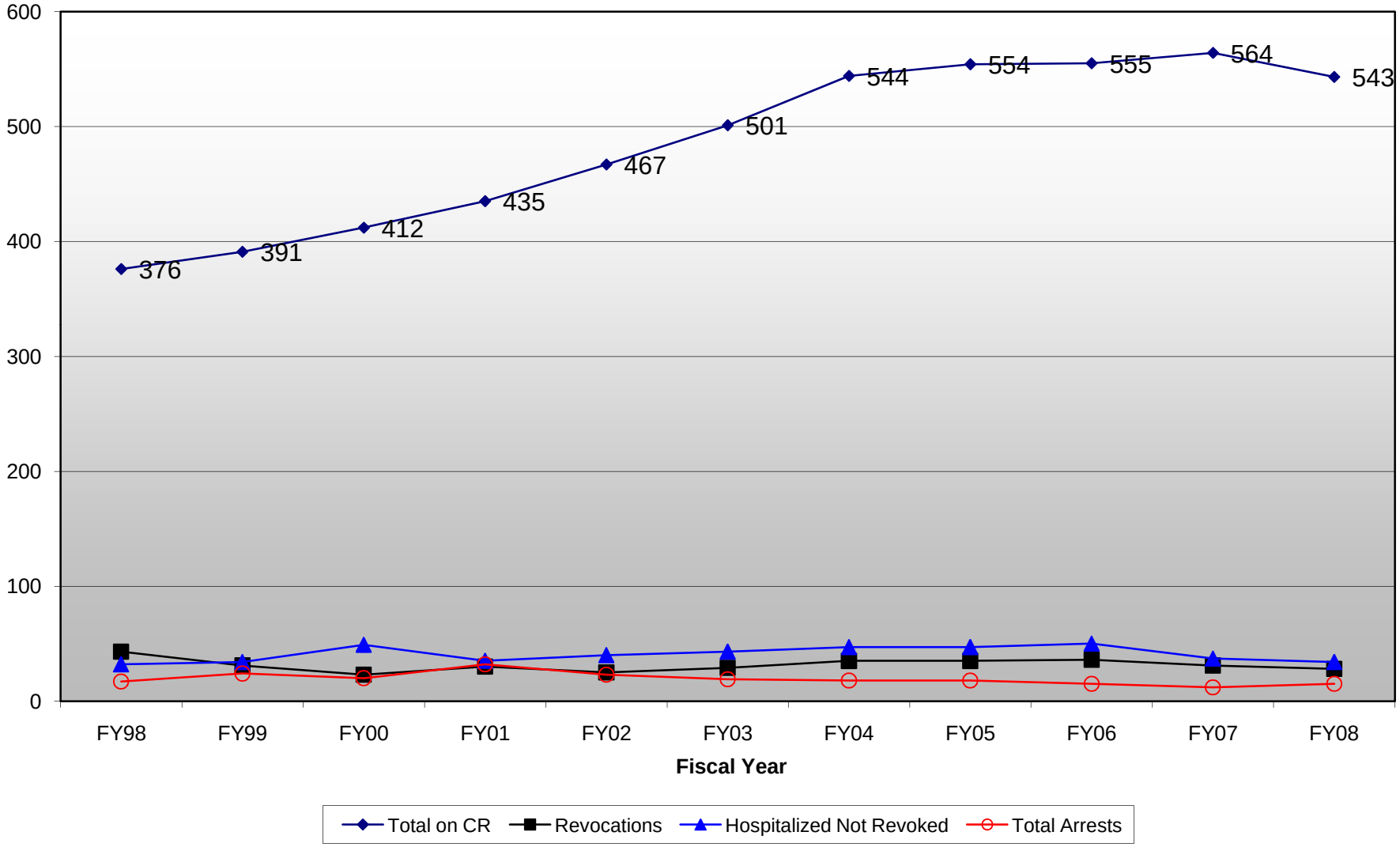


Please Note: This flowchart is intended to be a simplified overview of the forensic mental health system. Some information is not included. Consult the Ohio Revised Code Sections 2945.37 to 2945.402 for complete information.

Robert N Baker, PhD, OFS, 12-29-09

* Community-Based Restoration is Board financial responsibility

Number of People on Conditional Release FY98 - FY08



BENCHMARKING OTHER STATES								
STATE	**TRENDS IDENTIFIED**	**BARRIERS & CHALLENGES**	**BEST PRACTICES OR POTENTIAL SOLUTIONS**	**WHERE DO FORENSIC PATIENTS GO**	**DO FORENSIC CLIENTS GO TO DOC OR DO YOU SERVICE ANY FROM DOC**	**WHO PAYS FOR FORENSIC CLIENTS**	**WHAT IS CRITERIA FOR RELEASE FROM INPATIENT - CONDITIONAL RELEASE**	**FORENSIC EVALUATIONS PAYMENT? WHOM?**
Arizona - Has NGRI, IST-U (charges dropped w/o prejudice). Also have a SVP commitment but that is ran different. Services are provided by RFP's for each geographical areas & they provide ALL services no matter what - cannot refuse. The service provider also assists w/ placement & residency.	Restoration to competency small - ran by state but cost borne by county but has become an uncompensated mandate for rural counties (exemption have been given for small counties) large counties have begun their own program in jails.	Not enough housing. Anti-social personalities that surface even w/ the MI for the forensic pop.	Group home on campus - not licensed as a hospital but is able to mimic community living but still easily accessible by staff & vice versa. They do DBT, WRAP, Mentoring, uses GPS for some clients	State hospital	They do not go to DOC, occasionally they will service female DOC clients. Male are well provided for in own psychiatric facility	General fund that goes directly to hospitals. If on CR, then usually services are reimbursable.	Psychiatric Security Review Board - MH & correctional people. Appointed by the Director's office. Pt goes periodically for review or can be referred. If approved, referred to a comm. Provider. About 45 on CR in community. Only relevant for violent crimes. Guilty Except Insane (GEI) - presumptive sentence remanded to DOC but placed at state hospital for care & tx. May go to DOC if found no longer in need of tx. 120 people in program	Risk assessment & evals for competency paid for by court

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Connecticut - forensic population fairly stable. About 151 total w/ about 20% on conditional release	stable - criminal recidivism rate for this population has been 0%	Lots of training needed. Stigma no one wants them. Housing and residential services especially for high profile and violent offenses (sex offenses) May want level of supported housing to release but that level is not available	Good working relationships w/ all involved (community, tx providers, hospital staff). They have the ability to order someone to provide the tx.	State forensic hospital/unit	No	Hospitalization is state burden. Community is usually Medicaid reimbursed	Psychiatric Security Review Board (separate state agency). Individual clinical presentation. State will often time contest the hearing (similar to parole brd hearing in many ways but no set criteria on time served). People present include state attorney, defense attorney (stays w/ client throughout) clinical risk assessment, psychiatrist presents case. Use HARE/ABEL and other standard risk instruments	

STATE	TRENDS IDENTIFIED	BARRIERS & CHALLENGES	BEST PRACTICES OR POTENTIAL SOLUTIONS	WHERE DO FORENSIC PATIENTS GO	DO FORENSIC CLIENTS GO TO DOC OR DO YOU SERVICE ANY FROM DOC	WHO PAYS FOR FORENSIC CLIENTS	WHAT IS CRITERIA FOR RELEASE FROM INPATIENT - CONDITIONAL RELEASE	FORENSIC EVALUATIONS PAYMENT? WHOM?
Illinois - 5 forensic hospitals, 1400 inpt beds w/ about 50% forensic	Slight increase in forensic population. Usually 20-25 on a waiting list (used to run 30-50 so have reduced that)	Placement issues & getting folks out on conditional release	Try to do more outpatient restoration and increase community release. Potential solutions: 1) work w/ crts to move people out quicker 2) 21 days after restored must have court hrg 3) implemented performance measures/goals for restoration to more accurately measure & make clinical decision 4) do more outpatient work including CR & outpt restoration.	State hospital, usually in forensic bed	Occasionally get some from DOC if committed a crime in prison & need restoration services.	GRF state budget	Judge decides on ***conditional release*** after recommendation from clinical team. Person also can make a request but it is usually the team. Have 1 yr to restore. At 1yr can either drop charges & let go, extend period to restore or change to NGRI status. NGRI's avg about 5 yrs	Court pays & does initial evaluation. In Cooke County, they have their own forensic clinical services (part of the crt) & they do the evals themselves at that county, otherwise they are contracted out.
Indiana usually about 5 NGRI's per yr. Used to work in our system & ***feels it is very good - model***	Slow increase - should be noted though that they recently switched to AVATAR & data is not reliable. Not sure of current status. IST - referral rates increasing.	No misdemeanor distinction from felony - results in more referrals. Constant supply & some aren't restored then population increases. Direct admission from prison upon release can be problematic. Waiting list for civil	Faster at restoring to competency than in the past. 80% restored at 6 mos. But he believes Ohio is faster. They have outpatient restoration but not a good one.	State hospital w/ a few waiting in the jails if there is a waiting list	No forensic clients go to DOC but they do get some upon release.	State pays for forensic clients in state hospitals. There are no local boards (like our system) - state contracts locally w/ community mental health centers that provide direct services.	NGRI - up to tx & community team. IST-U roll over to civil commitment. Charges are usually dropped at time of maximum sentence, although they don't have to be dropped. ***No conditional release***	All evals are done outpatient and **paid by the county**. Statutorily, state employees cannot do them.

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Missouri - about 400 in hospital & about 460 on conditional released - ***has reviewed our system & likes it, feels it is a model***	Tremendous increase in incompetent to process. NGRI's very few & no increase. Honor Jackson "restored within the reasonable future"	Housing big barrier in getting them back to the community	CR = highly organized w/ only about 3% recidivism rarely new crim. Increased funding for residential & enhanced services in the comm. Fulton state hospital is doing social learning technology - EBP	If not restored w/in reasonable future, become civilly committed or are given a guardian who then voluntarily commits the individual.	No forensic patients go to DOC unless waiting at jail due to wait list. Mental health does provide staffing for a couple of units w/in DOC to provide services. There are a certain number of beds in the state hospitals that are retained for DOC, no exchange of funds for these beds.	Forensic clients inpatient come out of general state budget. General assembly directly funds money to community mental health centers who provide the community treatment, including the monitoring & assists in discharge planning.	***Conditional release*** **-** released by court (major crime = court of conviction, minor offense = local probate court). Others who have been civilly committed or placed under guardianship ***are*** released by clinical team or hospital. If has a guardian, must have consent of guardian	First one if done by the department of mental health at no charge. If someone asks for another, then it has to be paid for by whoever requests it (usually the defendant). Done via outpatient, sheriff retains custody.
New Hampshire - currently 30 male & 10 female beds. Plan to increase by 10 (to 40 male beds) by 2010	* Little bit of increase Anticipate increase in SVP	Difficulty transitioning from most restrictive (DOC) to least restrictive (state mental hospital) Then difficult to get into community especially NGRI's due to community perception & judges concerns.	All NGRI's, SVP are committed to DOC who oversees forensic. Step down is from DOC to sister agency dept of mental health state hospital. Exploring good risk assessment that takes into consideration both criminal risk and mental health risks	First go to DOC - forensic budget is embedded in DOC budget. No forensic line item in mental health budget	Yes - initially can then be transferred down to state mental hospital.	State pays for forensic in the DOC line and then state pays for clients when they transfer into a regular state hospital bed. These clients in the state system but the money is not tracked separately. Disproportionate share 9about 50%) when they go to state hospital is Medicaid reimbursed	All go in front of a judge inclusive of all levels & privilege increases. Prosecutor and defense attorney makes recommendation and the DOC commissioner must sign off on it to move from DOC to state hospital. ***Conditional release*** is possible for NGRI's and civil patients but not SVP's.	Forensic evaluations are completed usually on an outpatient basis. DOC has oversight over the forensic examiner and its **funded through general funds**. All psychiatric services are contracted out & this includes evaluations are part of the contracted services

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North Carolina - about 690 (230/hospx3) beds total. Forensic beds	In flux due to beds being decreased. Overall the population is remaining about the same. Slight increase in NGRI population due to no conditional release. They continue to pile up.	Diversion programs (CIT MH courts not catching on). Housing can be barrier. No conditional release can be barrier	Release clients into community but still under "inpatient forensic status". Check in daily. Some work & do regular community living but must check in. Difficult to get clients released	Forensic bed in state hospital	Pretrial inmates may be placed in jail if cannot be handled in state hospital bed	Very few people are assigned a forensic bed - which then shows little forensic expenditures. NGRI's are the only ones mandated to be in a forensic bed. Have local management entity that arranges contracts and providers bid on the services.	***No conditional release***. Guidelines for the judges 5yrs = misdemeanor; 10 yrs for felony. Homicide/murder hard to ever be discharged.	Inpatient occurs in general hospital bed so would come out of general hospital funds (not forensic) they are done by internal evaluators. Most are done on outpatient status but by internal evaluators. 850 last year, which is down from previous year.

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Pennsylvania 1600 beds about 38% are actually forensic, document 238 forensic beds. ***See Ohio as a model***	Major union issues - it impacts how clients are classified (forensic vs. civil). Very few NGRI's (about 4/yr). Are seeing an increase in criminal justice clients in civil beds (but not calling them forensic)	Union Issues No conditional release Stigma - no one wants them returned to comm. Housing huge prob benefit reinstate payment for tx. No forensic office - barrier to adequately planning & providing services in most efficient manner.	Would like to suspend vs. terminate on benefits Initiative to convert comm MH program to supportive living project. Working w/ CJ world to facilitate better communication. Looking at master lease for a bunch of apt to move folks into easily. Commented on Justice Stratton's kitchen cabinet to facilitate policy making. Commissioner on crime & delinquency just developed CJ center of excellence that they invited MH to be involved w/.	State hospital - some forensic bed some civil	Do provide 3 beds for female DOC inmates. DOC has 5 state prisons that have acute psychiatric units that are licensed and one long term unit (all licensed by DMH) State hospital.	Out of general budget for both forensic and civil. Budget is small due to formally recognized number of forensic beds	Clinically stable, develop a community d/c plan. Judges want to keep in for punishment/safety - have to ask the judge to approve the plan. Out patient commitment an option but rarely used. ***No conditional release.*** Charges cannot be dropped - can remain incompetent status forever (maximum sentence or 10yrs whichever is less but murder is for life)	Initials are done locally at jail or outpatient, hired by county court & court pays. These are contracted out as needed. Once determined to be incompetent & referred to a forensic bed for restoration, state completes. Recently, the state offered state psychiatric time to local courts to do these (due to quality & costs) but few have taken up on the offer.

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South Dakota	Showing increase in number of IST & NGRI & largest increase in forensic evaluations. Considering a forensic unit as they currently do not have one.	Few forensic trained psychiatrists - barrier. Risk of housing them w/ general pop. Security is not very high tech	Training is a solution - they have a lot of nationally renowned individuals come in as often as possible to provide training.	State hospital, general bed	They receive some patients who are court ordered from jail. DOC manages their own.	General revenue funding - no forensic line, thus expenditures show zero on forensic patients. Overall structure is community MH centers that provide direct service - they do a budget request from the state to operate. Involuntary admissions are paid by local. Forensic by state.	Court order release, clinically structured plan. ***Conditional release allowed.*** Incompetent to proceed - hospitalized under criminal code & remain until competent or charges dropped. CR, for some patients & yearly return for competency evaluation	court orders & pays a $500 admission fee that covers the cost of the evaluations. If found to be incompetent, then state begins to pay.

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West Virginia - no sexual commitment law but folks trying to commit this population anyway. No MRDD facilities in the state (like our developmental centers) this has resulted in quite a few MRDD/sex offenders residing in state MH hospitals. Local agencies are involved at time of d/c tx recommendation	Prior to new Forensic Director, very little data gathered. Two yrs there was approx 14% increase in forensic population but this year seems to be stabilizing	1) Poor relationship & comm. btwn DMH, jail author, & corrections. 2) Competency evals out of control (cost, number of them, types of them) 3) Judges still want to punish, so aren't interested in CR often times. Also nnow sending Parole/probation clients attempting to get them in through backdoor if sex offender	They have recently opened 3 forensic group homes, 8 beds each at a cost of approximately $171/day (vs about $300-$400). For long term clients that probably will never live independently. Also pay for transitional living facilities w/ 12 beds to prepare for indep living	3 forensic units w/ approximately 95 total forensic patients. Getting ready to build 50 beds unit	No w/ exception that they have a Maximum security unit in a jail for the most serious forensic client. It is a 4 bed unit	GRF funds. In transitional living, no benefits paid for by state. When in group home, able to get benefit & offset cost w/ benefits	Clinically stable. Have a Forensic Review Services brd consists of Medical director, hospital CEO, SW, Forensic Director. Process 1) tx team recomm 2) Indep. Eval by forensic fellow if yes, then to (if no, process stopped) 3) FR Services Brd review, if yes, then to judge (if no, process stopped). They have CR for NGRI's. Have catchment areas w/ Community MH Facilities that provide direct service	State - out of control w/ costs and protocols

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Michigan - indicated is somewhat structured like Ohio w/ boards but she did not believe exactly. They have no role in this population for the most part. May have a slight role at time of d/c from regional hospital for NGRI's in regards to signing agreed upon plan. None on IST-U's - they are recommited as civil probate - brds have no role in d/c or admission.	Percentage/proportion has gone up but believes this is a reflection of overall beds going down & not indication forensic population has gone up. Forensic center is 100% forensic, regional hosp run about 50% forensic pop.	Housing - lack of (she referenced Warren Culver case - although I did not have time to research this). For NGRI's, even though commitment is supposed to be same as civil commitment, based on this population, sometimes it is not really the same "punishment" vs. true need for hospitalization.	Not really doing anything particular	NGRI 100% must first go to Center for Forensic Psychiatry (forensic Hospital). IST about 2/3 go to regional hosp & 1/3 go to forensic hospital based upon assessed risk & severity of crime.	No - unless dual sentence such as NGRI or IST on one crime & previously convicted on anther then may spend time in Forensic hosp the NGRI/IST	MH code indicates must seek reimbursement when feasible, but rarely is Forensic hospitalization reimburseable. State & county share responsibility. When in forensic hospital the split is 90% state & 10% county. When in a regional hosp, the split is 90% county & 10% state.	Risk mgmt issue, judge has final approval. Potential for recidivism is huge factor that is considered for release. Has "authorized leave" status = conditional release. NGRI very formal process w/ hosp/brd/pt/tx provider all signing formal contracts.	Didn't ask

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New York - have a brd system. Very little role at all. They are looking at restructuring their system to streamline funding for all outpatient/community programming. NGRI's on conditional release usually go to state operated services vs typical community agencies, therefore, no brd involvement	Lots of litigation centered on serving the Correction's population, #/hrs of tx/day, d/c planning, benefits, housing & case management. For DMH forensic population, NGRI's have remained steady but LOS has increased from about 7 yrs in 80's to about 12+ yrs now. recent case law has dictated more holistic dangerousness evaluations. 275 secured status (most confining & serious), 325 in step down programs about 350 on CR. 2007 added civil confinement for	Structure that requires tx of correction population challenging. Lawsuits. Housing, Stigma, Fear & Misconception (actual risk vs perceived risk) by many in the community including judges etc.	Very thorough risk assessment program based upon & in consultation w/ national experts. It is recalibrated as new research is released (2 annual reports on-line at their website that explain it in more detail). 25 Pre-release Coordinators that do 1) reentry, 2) housing planning 3) benefit application/coordination 4) medication planning. Have a Med grant program that provides meds up to 3 months (not exactly sure length of the supply but thought he said 3 months) while benefits are pending.	Secured forensic tx center plus 3 forensic hospitals + 1 unit. Total 695 beds plus 230 SO beds (does not count the correction's hospital)	They do provide services to correction's population (all levels). There is a hospital unit (JCAHO) within DOC = 191 beds. About 8500 offenders on case load in prison w/ about 1/3 being SMI.	IST - county pays at 50% of per diem rate. Statute indicates NGRI's are self pay, but most are indigent so do not get paid - state absorbs the cost.	Regs indicate each hospital that has forensic clients must have team consisting of 3 licensed individuals, 1 who must be a certified psychiatrist. They review, make recommendation to Clinical Director, to Forensic Director, to court for CR. No outpatient restoration for IST's. Only CR for NGRI's.	Did not ask

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Oregon - left several messages. Most recent, staff were off on state mandated furlough day								

Forensic Monitor/LAA Feedback
Efficient Practices

Issue	Efficient Practices	Further Recommendations
1. Clients getting "bottlenecked" in the system (in the hospital due to FRT, reports, 2nd opinion, etc.). Also, there is a separate problem with people being backed up in hospital when there is no community housing available.	1. FM and LAA/hospital staff meet 2x/month to address these people – what else can be done to move them along, where/what is the hold up 2. Ask for Level 5 and CR at the same time 3. Implemented time lines	Forensic Center Evaluations make recommendations that allow levels 3 & 4 at start of NGRI or IST-U-CJ commitment • Happens well in Cuyahoga & Summit County • 2nd opinion within 30 days • How valuable is FRT Concept? (ODMH policy) – Can we streamline
2. People who may need little to no hospitalization but end up there due to lack of plan.	1. Get involved very early (one person looks at court admissions for recognized names &/or specific crimes daily) and then follow person with a plan in mind 2. Increase Utilization of Outpatient Restoration 3. Provide competency restoration in jail while patient is waiting for bed 4. Use the "New York Model" and eliminate MCT 38B's if they're found IST at the time of the initial competency evaluation	2a. Define Outpatient Restoration Program better so all knows what it entails. 2b. Educate all that it is available 2c. Try to identify resources necessary statewide in order for outpatient restoration to be used 2d. Cuyahoga & Summit County
3. Huge numbers from a few counties have the greatest impact on overall numbers statewide.	1. Concentrate changes on 3-4 biggest counties to have the largest impact 2. Changes to smaller counties are important for overall management, but if only relatively smaller number, even if practice is changed 100%, overall impact on state is small	1. Drill down on high-users counties 2. Regionalization
4. Placement/Residential Needs – People spending too long in hospital because of no appropriate housing in community.		Concerns over ACF funding • Clients historically "burning bridges" • Report Recommendation
5. Forensic Review Team (FRT) takes too long. a. Review for streamlining and standardization.	1. If treatment team plans to do CR, 10 day notice before pre-d/c meeting 2. If known going to ask for CR, then fax request early to get on list for 2nd opinion evaluation (increases timeliness) earlier 3. Have a "watchdog" to monitor progress/status of the HCR-20	1a. May be referencing HCR-20 – Should speed up after becoming more familiar. 2a. Quicker timelines for FRT process. 3a. The Clinical Director or the Psychology Supervisor or the LAA can play this role.
6. Some NGRIs being hospitalized unnecessarily because of overly conservative LRE evaluation by Forensic Center; they could go straight to CR.	No progress identified	Could develop standardized risk assessment process at Forensic Centers and do more training concerning community resources for Forensic Monitoring.
7. Misdemeanants who have been previously found unrestorable to competency	None Developed	Develop a process to "tag" misdemeanants who have previously been found unrestorable so that evaluation resources can be saved if the person is referred again to the Forensic Center.

Forensic Strategies Workgroup

Data Appendix

Handouts:

Forensic Strategies Workgroup

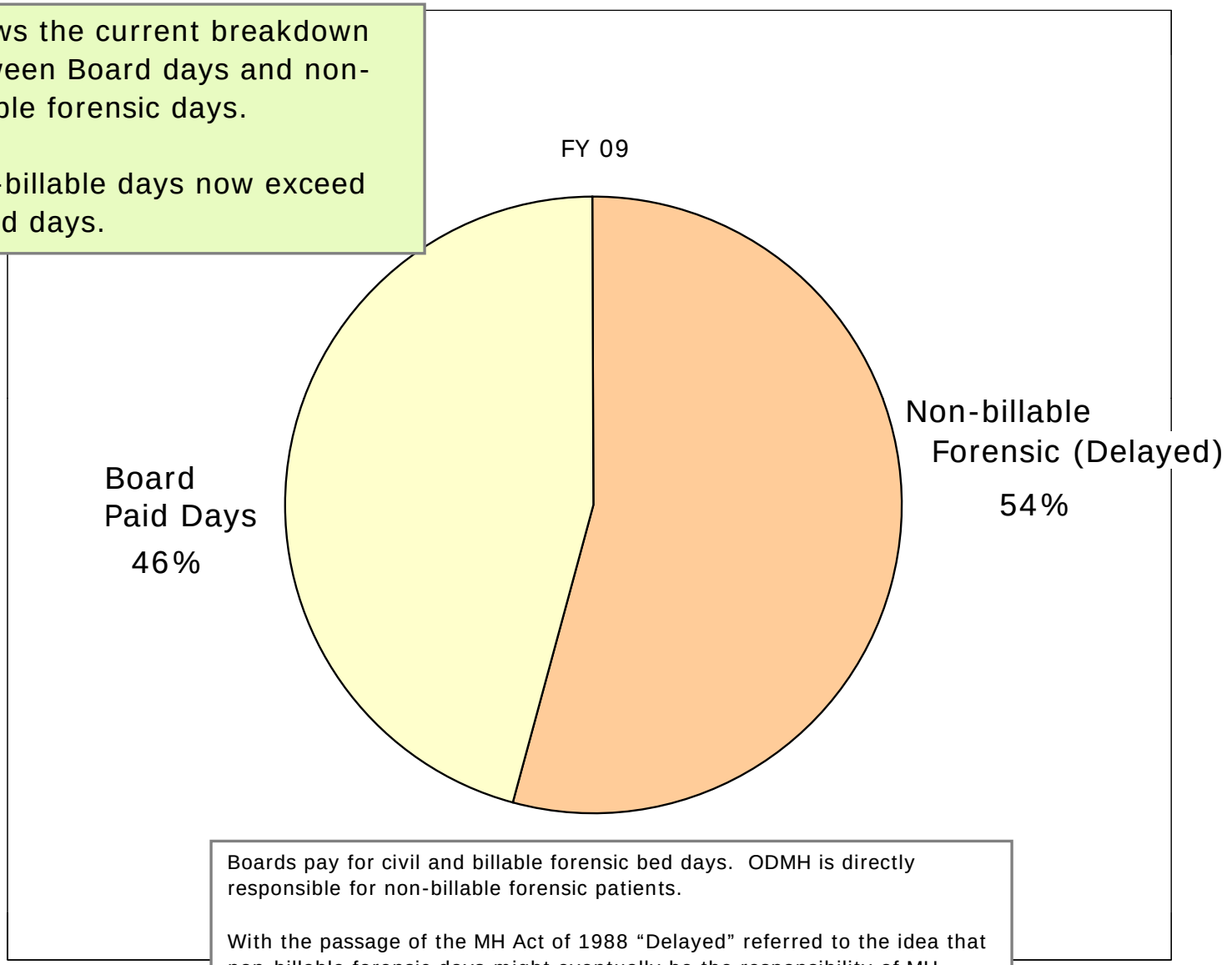
Data Presentation

Updated for September 21, 2009 Meeting

How State Hospital Bed Days Are Typically Divided

Shows the current breakdown between Board days and non-billable forensic days.

Non-billable days now exceed Board days.

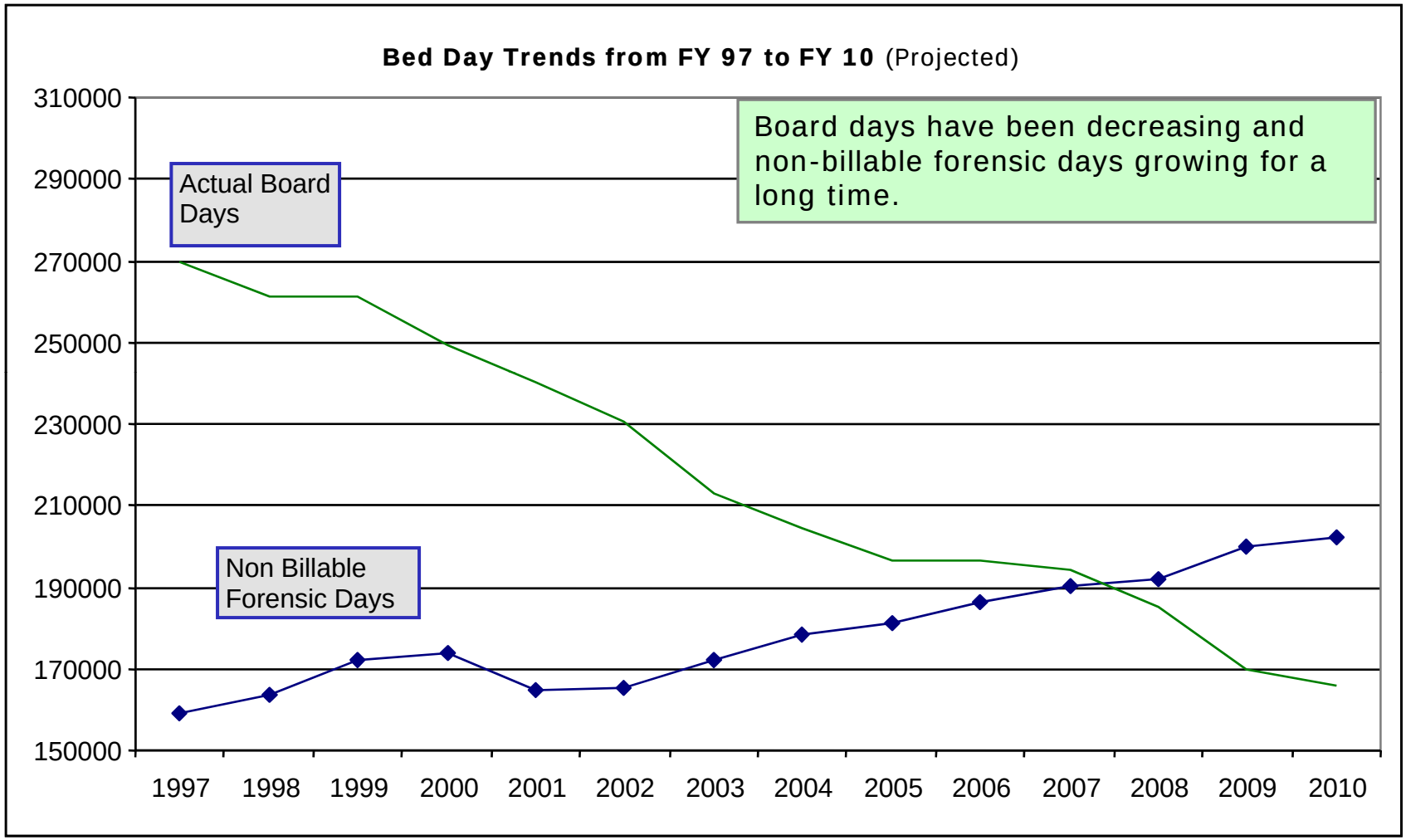


Boards pay for civil and billable forensic bed days. ODMH is directly responsible for non-billable forensic patients.

With the passage of the MH Act of 1988 “Delayed” referred to the idea that non-billable forensic days might eventually be the responsibility of MH Boards rather than ODMH.

Forensic Strategies
Handout for 9-21-09

Board and Delayed Bed Day Trends



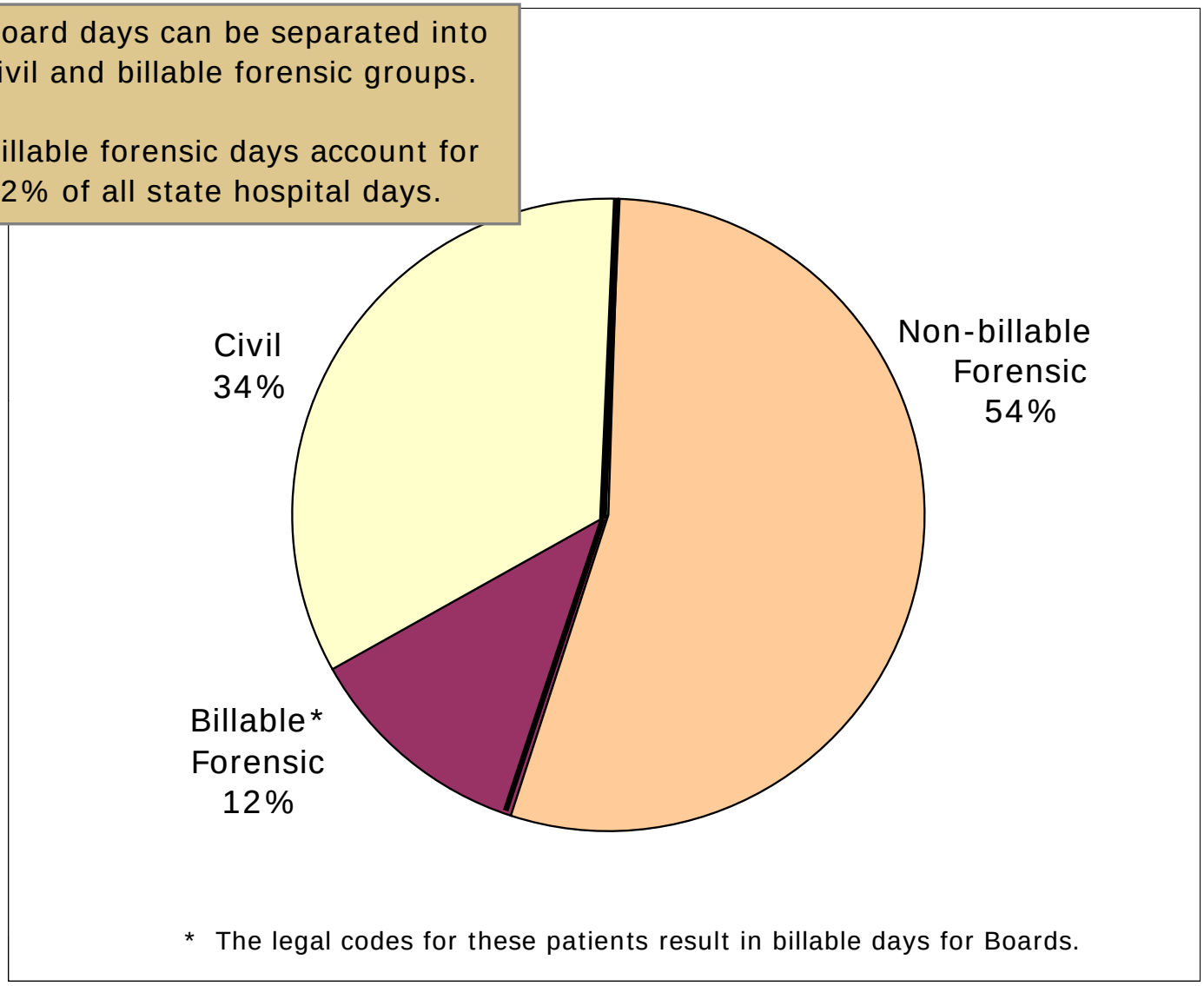
State Hospital Bed Days

Forensic Strategies
Handout for 9-21-09

‘Billable’ Forensic Days

Board days can be separated into civil and billable forensic groups.

Billable forensic days account for 12% of all state hospital days.



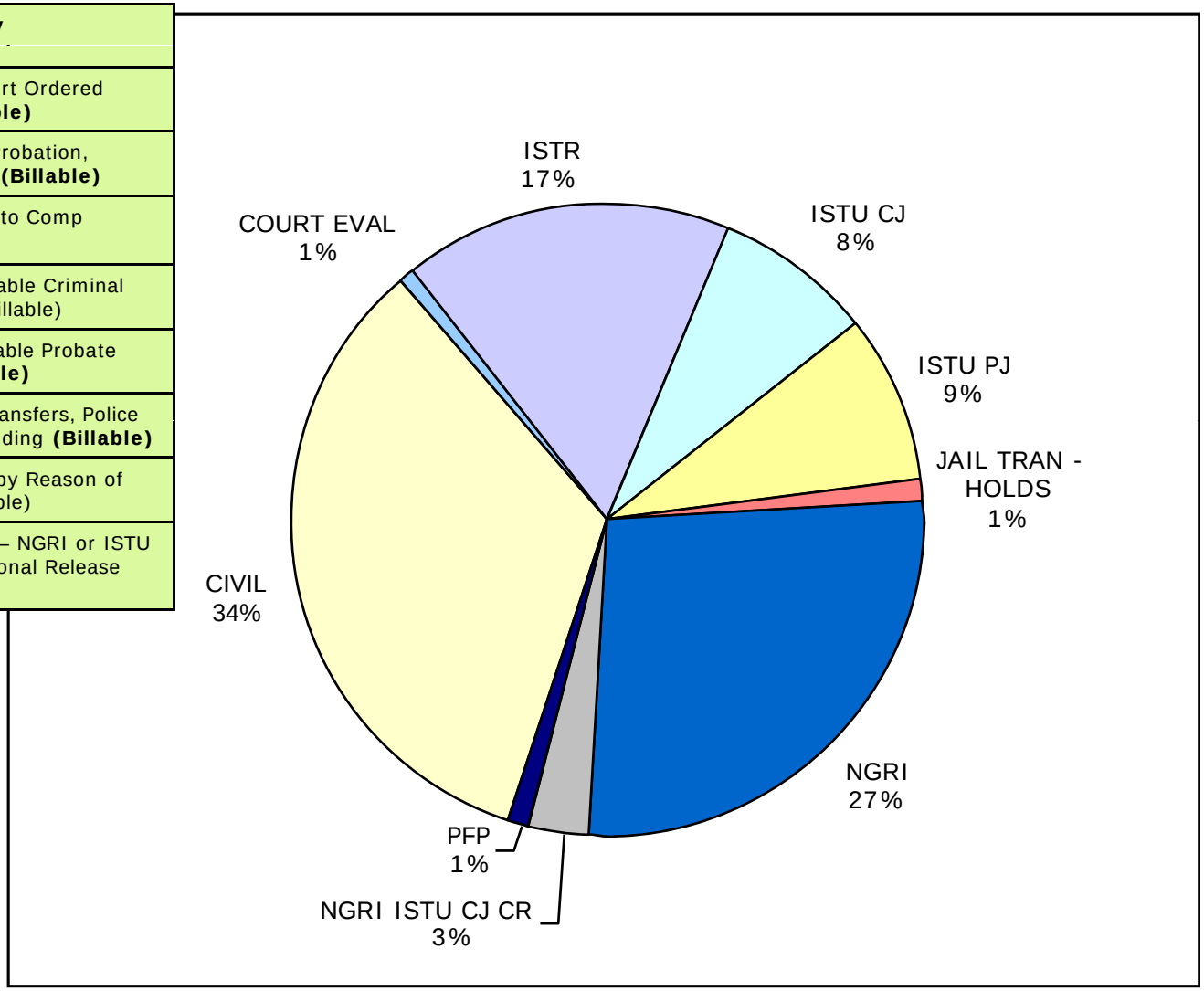
* The legal codes for these patients result in billable days for Boards.

FY 09 State Hospital Bed Days

Forensic Strategies
Handout for 9-21-09

Breakdown of Forensic Categories

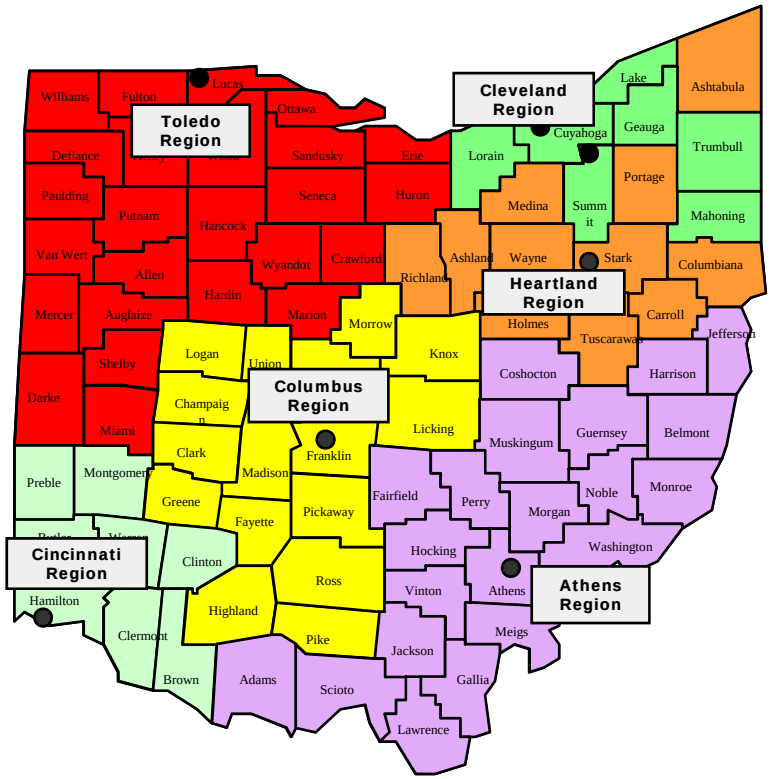
Key
COURT EVAL – Court Ordered Evaluations **(Billable)**
PFP – Patients on Probation, Parole or Furlough **(Billable)**
ISTR - Restoration to Comp (Non-billable)
ISTU CJ - Unrestorable Criminal Jurisdiction (Non-billable)
ISTU PJ - Unrestorable Probate Jurisdiction **(Billable)**
JAIL TRAN – Jail Transfers, Police Holds, Charges Pending **(Billable)**
NGRI – Not Guilty by Reason of Insanity (Non-billable)
NGRI /ISTU CJ CR – NGRI or ISTU patients on Conditional Release (Non-billable)



FY 09 State Hospital Bed Days

Forensic Strategies
Handout for 9-21-09

ODMH State Psychiatric Hospitals



Hospital	Types of Inpatient Forensic Work	Region
Athens	Restoration to Competency; Treatment of NGRI Acquitees; Competency / Sanity Evaluations; Treatment of Patients Found Non-Restorable by Probate or Criminal Courts	SE Ohio
Cleveland	Restoration to Competency, Restoration / Sanity Evaluations	NE Ohio
Northfield	All	NE Ohio
Heartland	All	North Central Ohio
Northwest Ohio	All	NW Ohio
Summit	All	SE Ohio
Twin Valley	All	Central Ohio

Forensic Strategies
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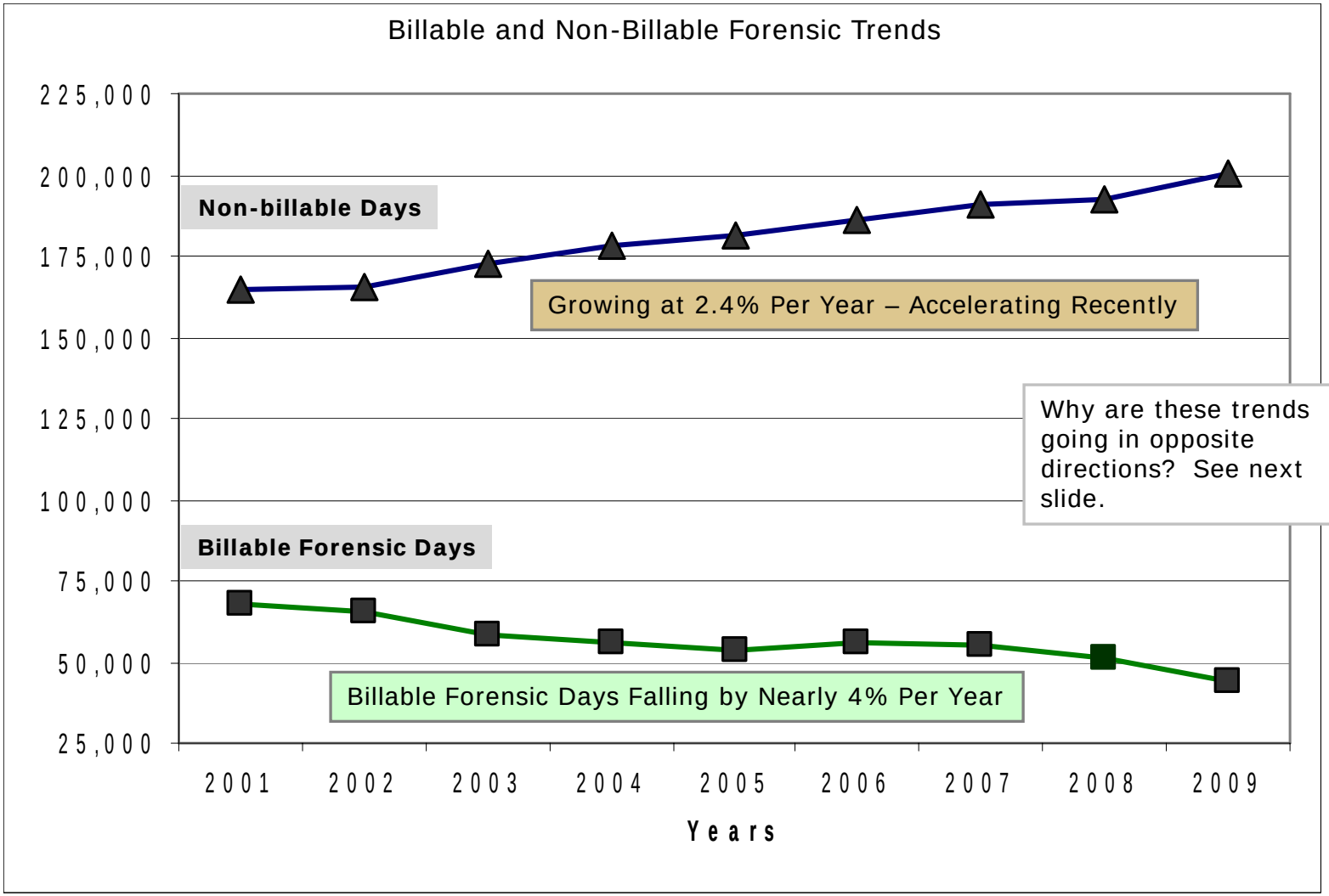
State Hospital Forensic Trends



State Hospital Bed Days

Forensic Strategies
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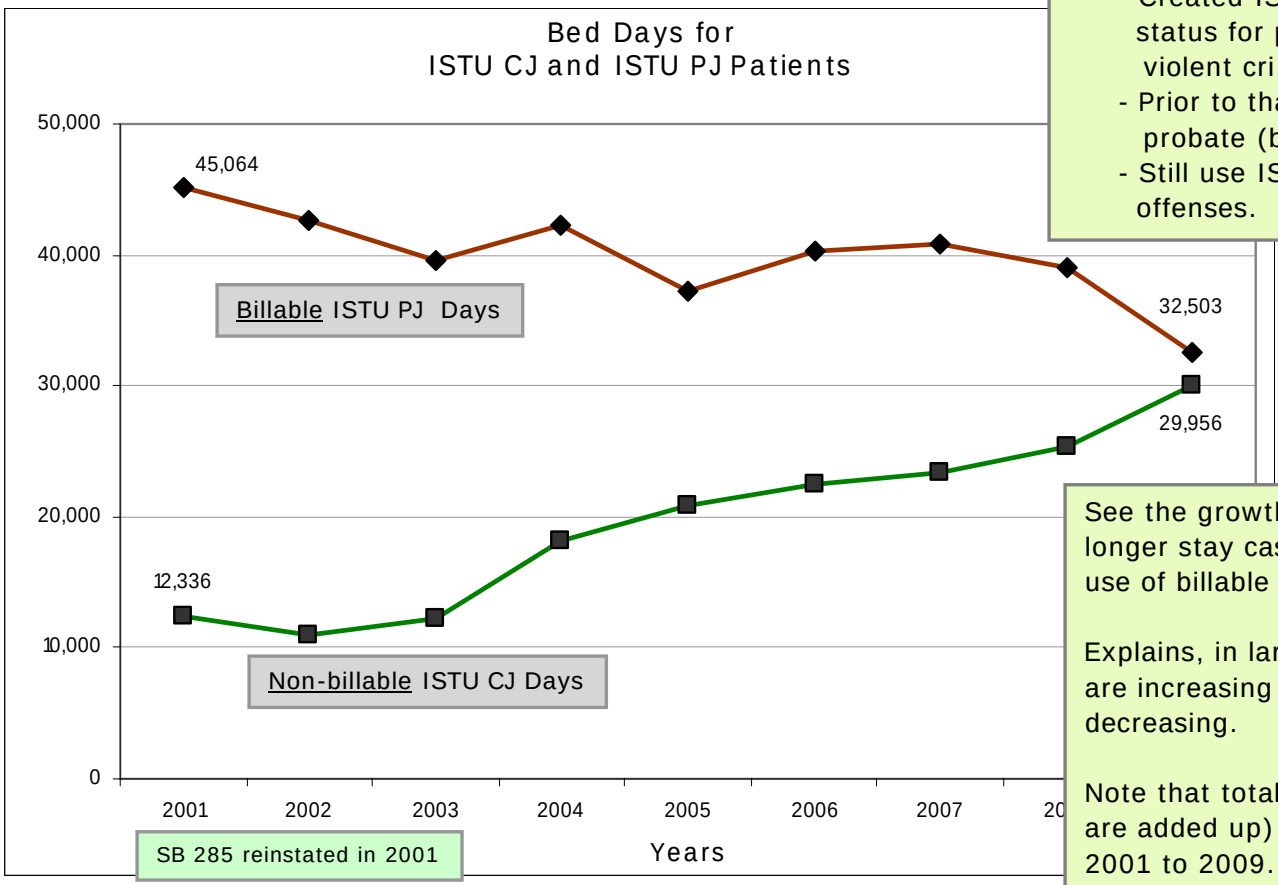
Why Are Billable and Non-billable Trends Going in Opposite Directions?

Senate Bill 285 changed the ISTU process:

- Created ISTU CJ (criminal jurisdiction) status for people charged with more violent crimes
- Prior to that all ISTU patients were probate (by default) to local Boards
- Still use ISTU PJ for less violent offenses.



See the growth of CJ status for more violent, longer stay cases, taking away / reducing the use of billable PJ status.

Explains, in large part, why non-billable days are increasing and billable days are decreasing.

Note that total ISTU days (when CJ and PJ are added up) are practically unchanged from 2001 to 2009.

State Hospital Bed Days

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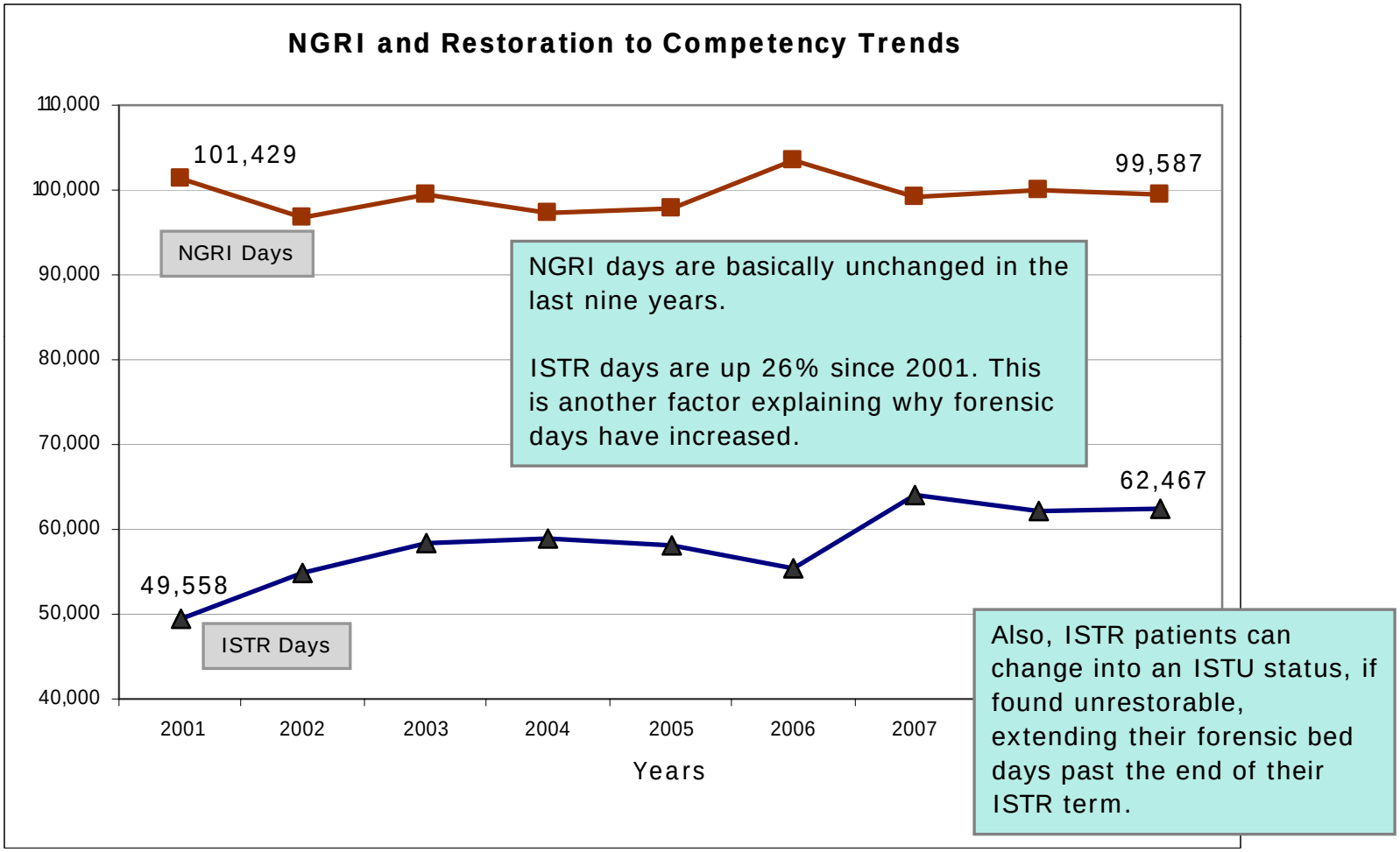
Any Other Reason Why Forensic Days Are Growing?



* Senate Bill 285 establishes ISTU CJ legal status

State Hospital Bed Days

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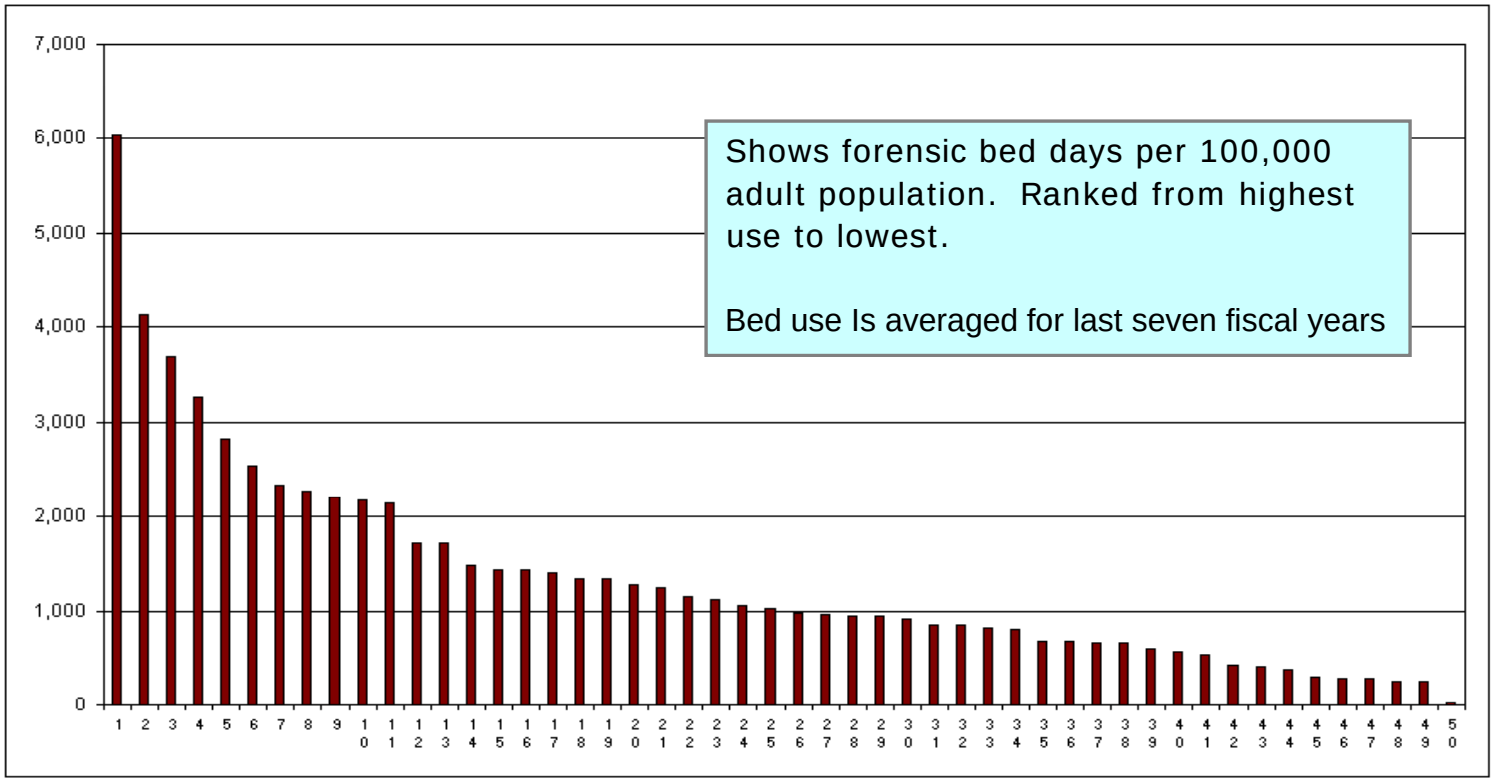
Board Variation in Forensic Hospital Bed Day Use



KEY:

1 HAMILTON
2 LUCAS
3 MONTGOMERY
4 ASHTABULA
5 CUYAHOGA
6 MAHONING
7 FRANKLIN
8 SUMMIT
9 TUSCARAWAS-CARROLL
10 ATHENS-HOCKING-VINTON
11 STARK
12 BUTLER
13 ERIE-OTTAWA
14 GALLIA-JACKSON-MEIGS
15 WARREN-CLINTON
16 FAIRFIELD
17 WASHINGTON
18 TRUMBULL
19 SCIOTO-ADAMS-LAWRENCE
20 LAKE
21 LICKING-KNOX
22 UNION
23 ASHLAND
24 LORAIN
25 RICHLAND
26 DELAWARE-MORROW
27 ALLEN-AUGLAIZE-HARDIN
28 CLARK-GREEN-MADISON
29 CLERMONT
30 MUSKINGUM
31 HURON
32 BROWN
33 BELMONT-HARRISON-MONROE
34 SENECA-SANDUSKY-WYANDOT
35 COLUMBIANA
36 WOOD
37 ROSS-PICK-PIKE-FAY-HIGH
38 PORTAGE
39 WAYNE-HOLMES
40 VANWERT-MERCER-PAULDING
41 MIAMI-DARKE-SHELBY
42 HANCOCK
43 MEDINA
44 DEFIANCE-FULT-WILL-HENRY
45 PREBLE
46 LOGAN-CHAMPAIGN
47 GEAUGA
48 MARION-CRAWFORD
49 JEFFERSON
50 PUTNAM

Forensic Strategies
Handout for 9-21-09

Forensic Centers and Service Areas

Forensic Center	Counties Served	Hospital
Columbus	Franklin, Delaware, Fairfield, Fayette, Licking, Madison, Pickaway, Union	Twin Valley or Athens
Cincinnati	Hamilton, Clermont	Summit
Hamilton	Butler, Clinton, Preble, Warren	Summit
Dayton	Montgomery, Allen, Auglaize, Champaign, Clark, Darke, Greene, Logan, Mercer, Miami, Shelby,	Summit, TV or NOPH
Portsmouth	Adams, Athens, Brown, Gallia, Highland, Hocking, Jackson, Lawrence, Meigs, Pike, Ross, Scioto, Vinton	Athens, TV or Summit
Byesville	Belmont, Carroll, Coshocton, Guernsey, Harrison, Jefferson, Monroe, Morgan, Muskingum, Noble, Perry, Tuscarawas, Washington	Athens or Heartland
Akron	Summit, Geauga, Medina, Portage, Stark	Northcoast or Heartland
Youngstown	Mahoning, Ashtabula, Columbiana, Trumbull, Lake	Northcoast or Heartland
Mansfield	Richland, Ashland, Crawford, Hardin, Holmes, Huron, Knox, Lorain, Marion, Morrow, Seneca, Wayne, Wyandot	Heartland, TV , NBH or NOPH
Toledo	Lucas, Defiance, Erie, Fulton, Hancock, Henry, Ottawa, Paulding, Putnam, Sandusky, Van Wert, Williams, Wood	NOPH
Cleveland	Cuyahoga	Northcoast

Forensic Center Role:

The Community Forensic Psychiatry Centers perform competency to stand trial and criminal responsibility/sanity evaluations for Ohio's Courts of Common Pleas (ORC 2945.37; 2945.371) and "second opinion" evaluations for Ohio's Regional Psychiatric Hospitals (ORC 2945.401(D)(1)(b)). They also perform other types of evaluations for various courts and provide consultation and training services for the local criminal justice system, the MH Boards, and community mental health agencies.

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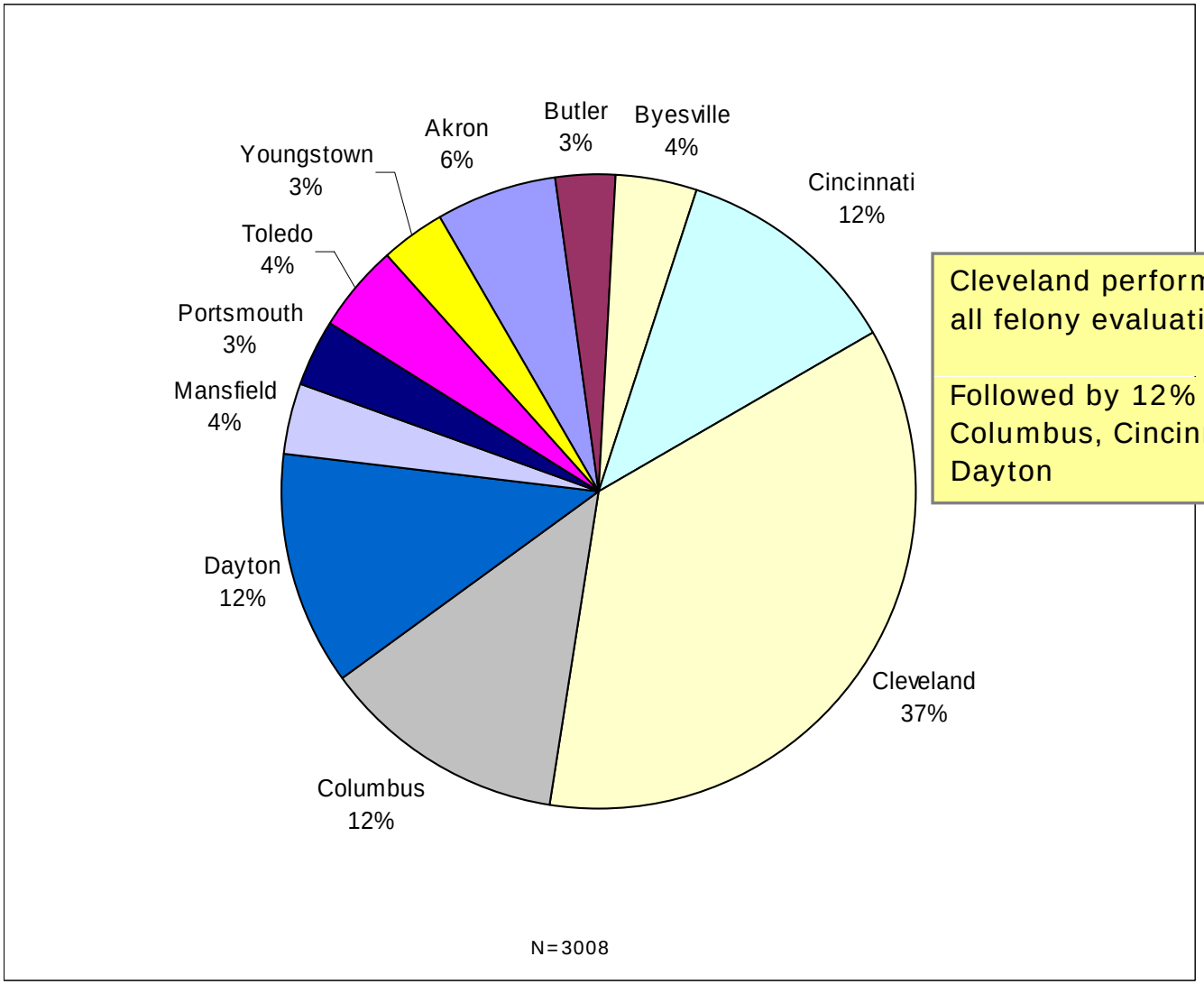
Forensic Center Competency and Sanity Felony Evaluations – FY 2009



Cleveland performs 37% of all felony evaluations

Followed by 12% at Columbus, Cincinnati and Dayton

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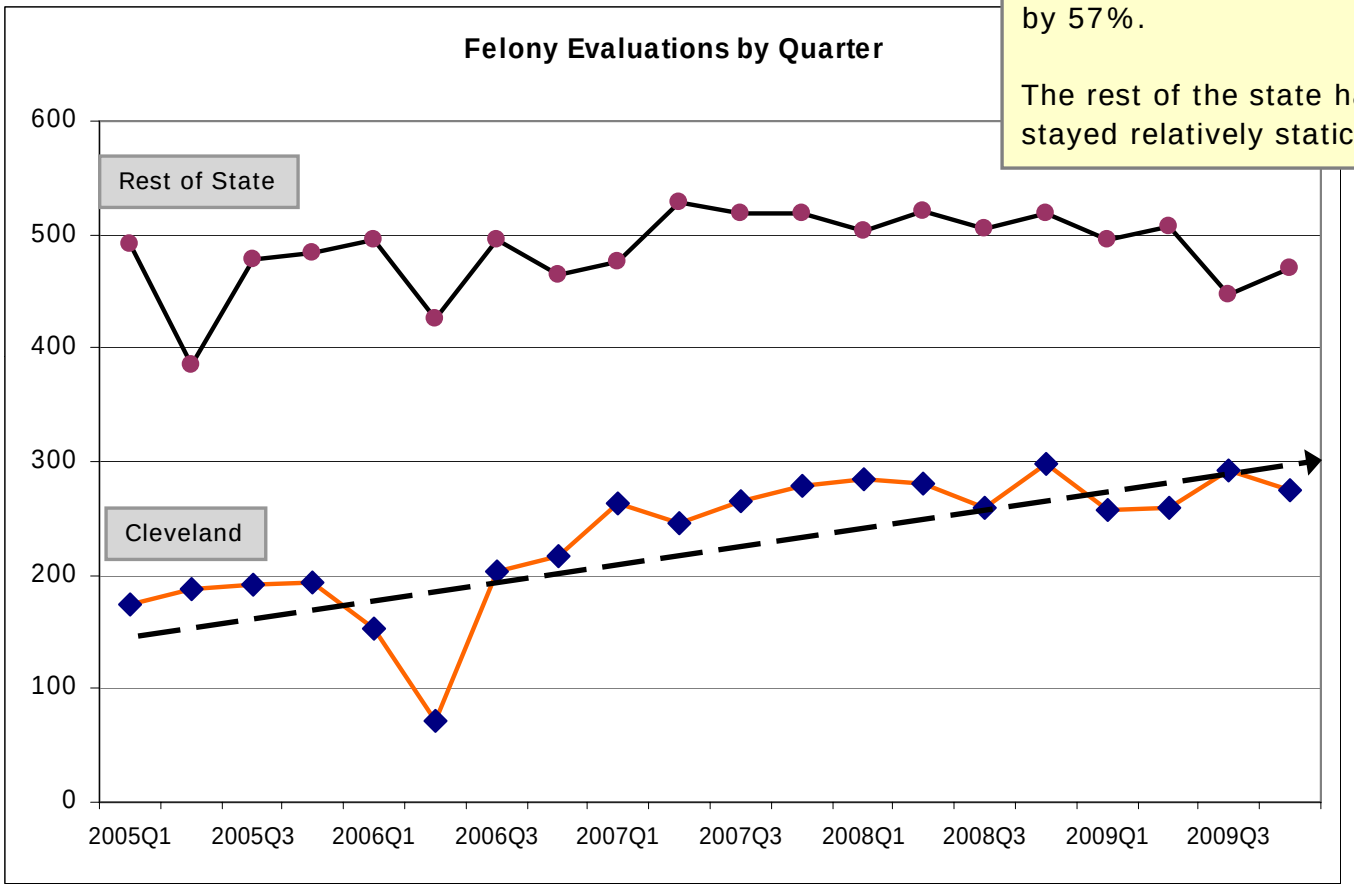
Felony Trends: Cleveland Center Compared to Rest of State

Since FY 05, Cleveland's felony evaluations have grown by 57%.

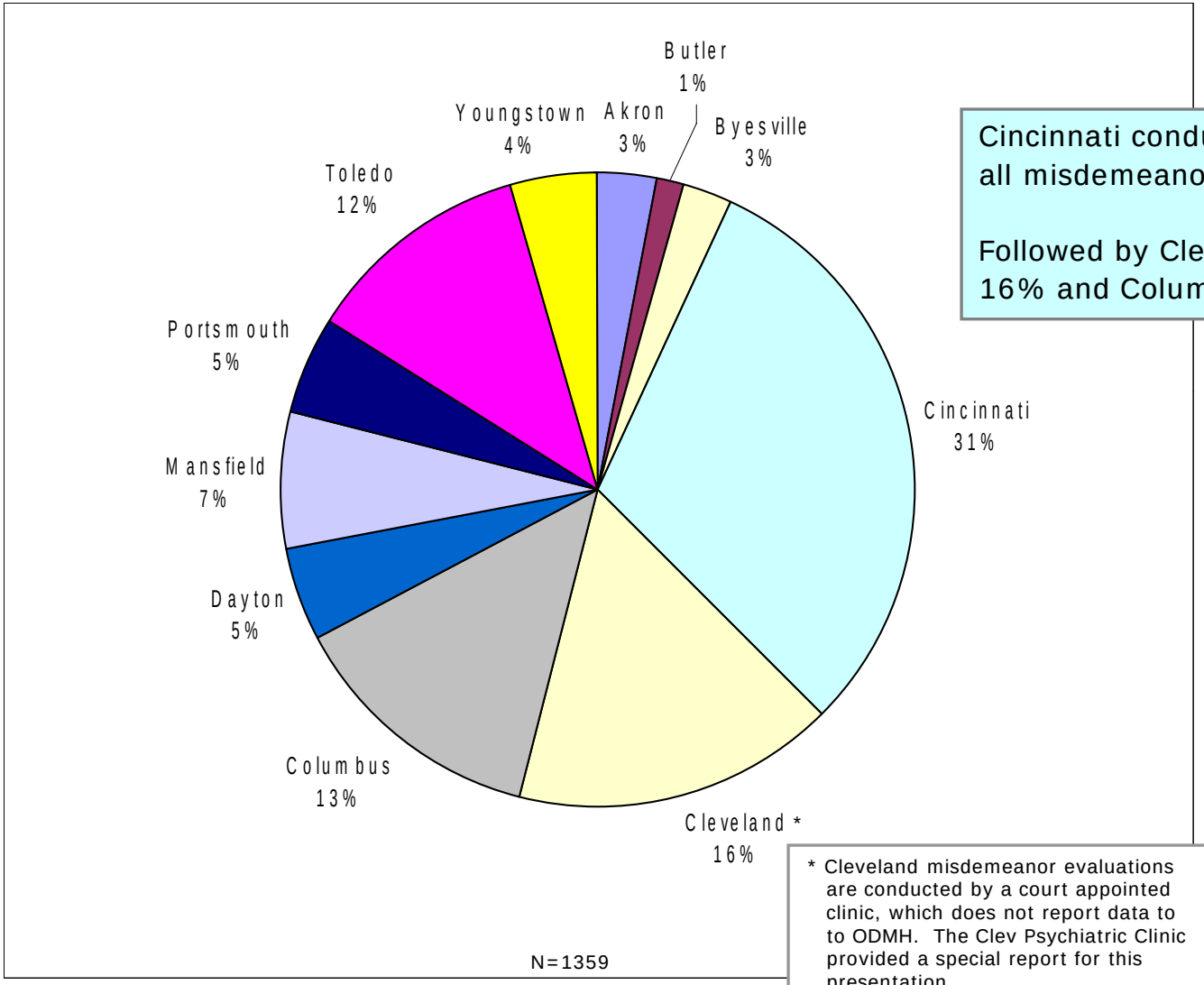
The rest of the state has stayed relatively static.



Data from Office of Forensic Services from FY 05 through FY 09

Forensic Strategies
Handout for 9-21-09

Forensic Center Misdemeanor Competency and Sanity Evaluations – FY 2009



Cincinnati conducts 31% of all misdemeanor work

Followed by Cleveland at 16% and Columbus at 13%

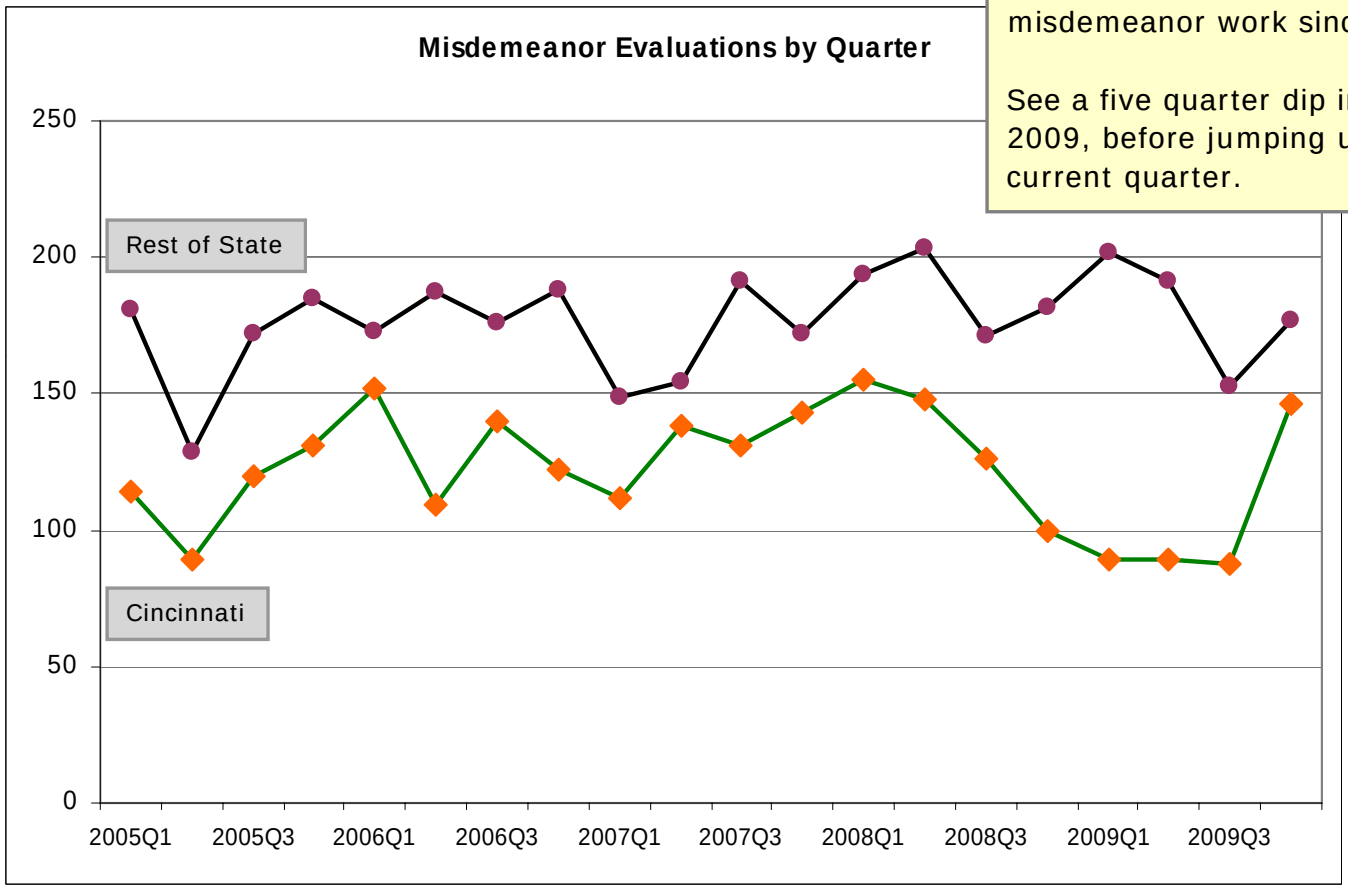
* Cleveland misdemeanor evaluations are conducted by a court appointed clinic, which does not report data to to ODMH. The Clev Psychiatric Clinic provided a special report for this presentation.

Forensic Strategies
Handout for 9-21-09

Misdemeanor Trends: Cincinnati Center Compared to Rest of State

Cincinnati has dominated this area, accounting for 41% of all misdemeanor work since FY 05.

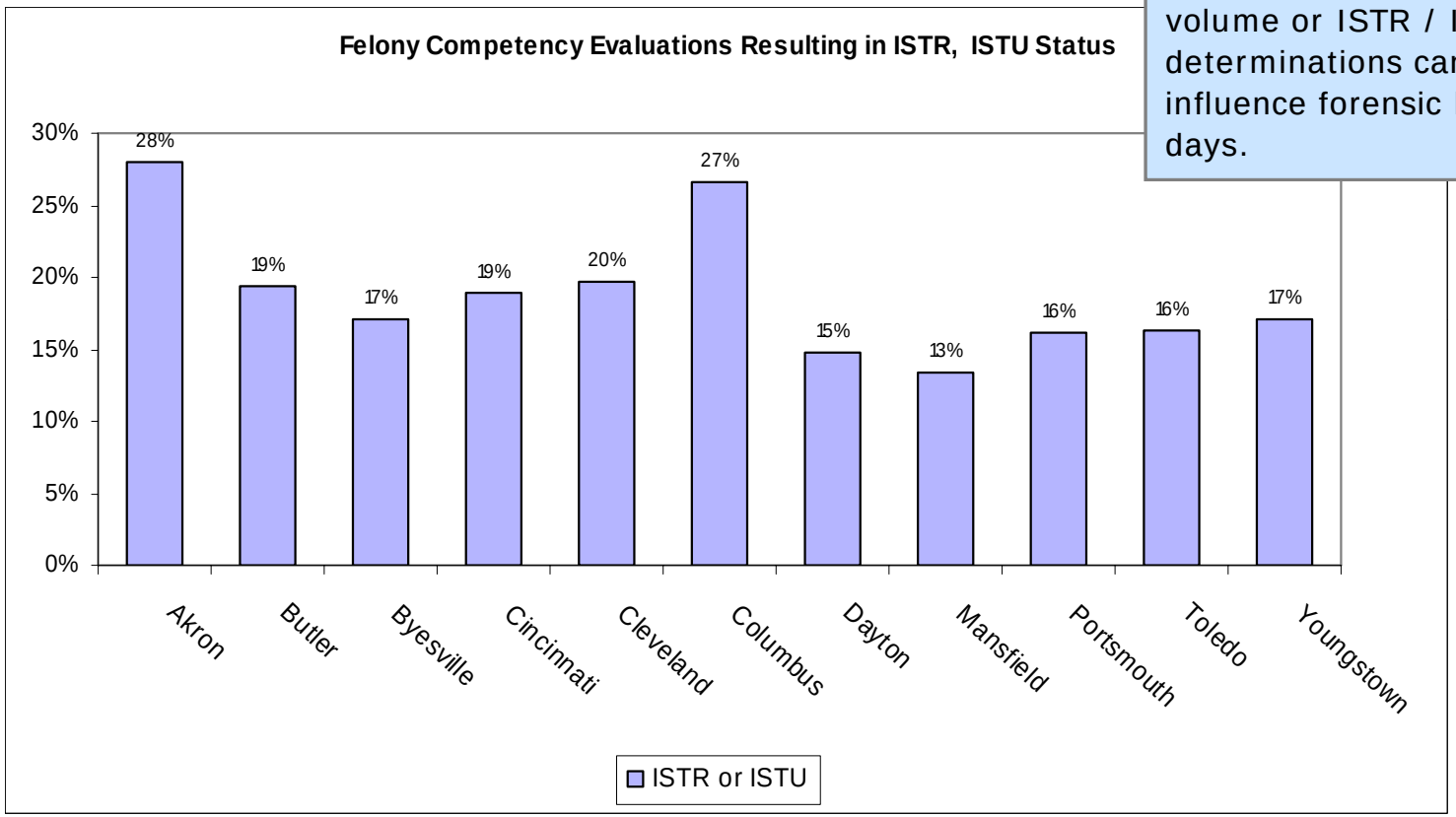
See a five quarter dip in 2008 and 2009, before jumping up in current quarter.



Data from Office of Forensic Services from FY 05 through FY 09

Forensic Strategies
Handout for 9-21-09

Felony Determinations by Forensic Center
Shows Percent of Cases with an ISTR or ISTU Outcome



Increases in forensic center volume or ISTR / ISTU determinations can directly influence forensic hospital days.

Data from Office of Forensic Services from FY 05 through FY 09

Forensic Strategies
Handout for 9-21-09

Length of Stay for Discharged Civil Patients

By Hospital and Fiscal Year

	Discharges				Median LOS			
Hospital	2006	2007	2008	2009	2006	2007	2008	2009
Athens	502	494	472	724	8	7	6	8
Cambridge	447	270	297		9	10	15	
Cleveland	1181	1109	1118	1091	10	12	12	11
Columbus	906	980	1180	1153	15	15	15	15
Dayton	624	520	477		15	15	17	
Heartland (Massillon)	856	900	679	762	12	9	11	9
Northfield	359	340	281	348	14	18	21	16
Summit (Cincinnati)	158	121	135	271	70	76	83	62
Toledo	342	313	265	259	17	17	21	22
Moritz	9	8	11	3	97	69	77	42
Total	5384	5055	4915	4611	12	12	13	13

Length of Stay for Discharged Forensic Patients

By Hospital and Fiscal Year

	Discharges				Median LOS			
Hospital	2006	2007	2008	2009	2006	2007	2008	2009
Athens	49	51	48	110	10	8	9	12
Cambridge	62	73	73		7	12	16	
Cleveland	211	193	175	203	54	51	56	44
Columbus	141	101	88	108	60	78	92	105
Dayton	110	129	159		46	38	83	
Heartland (Massillon)	112	116	112	124	27	26	33	20
Northfield	107	90	115	141	208	277	212	171
Summit (Cincinnati)	332	342	355	256	63	69	62	70
Toledo	128	119	100	127	36	30	41	34
Moritz	87	72	61	63	78	112	92	99
Total	1339	1286	1286	1132	55	55	60	59

Note:

- LOS average is based on the median LOS.
- LOS figures are for dicsharged patients only and based on admitting legal status.
- Forensic LOS includes billable and non-billable (delayed) statuses.
- Mortiz is a maximum security facility, operated by ODMH.
- Cambridge and Dayton were closed on 6/30/2008.
- The mix of forensic patient groups can vary a great deal aross the hospital sites, resulting in large median LOS variation. For example, Athens has the majority of jail transfers in our system, which tend to have a low LOS. Northfield, on the other hand, has a great many long term forensic patients (NGRI and ISTU CJ), which result in long LOS figures.

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Civil Median LOS by Board

	Discharges				Median LOS			
Board	2006	2007	2008	2009	2006	2007	2008	2009
ALLEN-AUGLAIZE-HARDIN	12	14	12	14	29	6	25	26
ASHLAND	24	32	34	32	13	8	9	6
ASHTABULA	103	125	55	62	8	8	7	8
ATHENS-HOCKING-VINTON	221	230	208	249	8	7	6	6
BELMONT-HARRISON-MONROE	88	70	67	65	6	14	11	10
BROWN	2		6	1	79		65	45
BUTLER	34	21	21	20	57	79	100	74
CLARK-GREEN-MADISON	37	32	31	17	14	15	21	26
CLERMONT	14	10	7	13	80	76	84	39
COLUMBIANA	30	37	32	31	13	12	16	14
CUYAHOGA	1048	1090	1077	1085	10	12	12	12
DEFIANCE-FULT-WILL-HENRY	58	62	48	15	12	11	9	29
DELAWARE-MORROW	30	30	35	31	17	10	20	21
ERIE-OTTAWA	24	22	22	21	20	12	28	28
FAIRFIELD	54	46	65	64	13	10	12	9
FRANKLIN	781	857	1084	1059	16	16	15	15
GALLIA-JACKSON-MEIGS	145	145	169	105	7	7	7	7
GEAUGA	30	27	30	37	6	9	9	12
HAMILTON	81	62	89	165	81	112	77	64
HANCOCK	13	11	14	13	15	20	19	43
HURON	6	4	11	3	26	70	33	14
JEFFERSON	27	22	7	19	11	19	20	14
LAKE	51	62	57	97	6	8	11	10
LICKING-KNOX	136	88	86	66	8	9	12	12
LOGAN-CHAMPAIGN	55	53	52	28	6	8	8	11
LORAIN	140	69	68	61	8	9	13	13
LUCAS	169	145	114	88	19	20	21	21
MAHONING	65	42	59	36	13	23	24	17
MARION-CRAWFORD	30	24	31	37	12	8	12	12
MEDINA	68	45	67	67	10	10	10	10
MIAMI-DARKE-SHELBY	68	89	38	26	7	8	17	21
MONTGOMERY	404	248	248	63	19	24	22	43
MUSKINGUM	160	129	156	106	9	9	15	10
PORTAGE	72	67	47	73	13	13	13	9
PREBLE	31	16	21	5	4	5	6	34
PUTNAM	11	4	7	16	7	13	24	10
RICHLAND	48	64	53	69	20	12	17	11
ROSS-PICK-PIKE-FAY-HIGH	54	62	51	54	10	12	13	13
SCIOTO-ADAMS-LAWRENCE	78	64	48	53	10	13	10	10
SENECA-SANDUSKY-WYANDOT	38	21	25	25	20	30	32	16
STARK	342	316	239	221	13	10	10	8
SUMMIT	82	70	54	28	25	46	30	35
TRUMBULL	119	115	66	96	14	15	21	22
TUSCARAWAS-CARROLL	13	9	10	13	14	7	14	9
UNION	24	24	20	9	7	8	7	13
VANWERT-MERCER-PAULDING	5	18	14	13	12	15	21	16
WARREN-CLINTON	37	56	19	10	42	13	77	50
WASHINGTON	55	44	43	21	6	6	9	9
WAYNE-HOLMES	150	138	88	101	7	9	10	10
WOOD	17	24	10	8	21	13	94	46
Total	5384	5055	4915	4611	12	12	13	13

Forensic Median LOS by Board

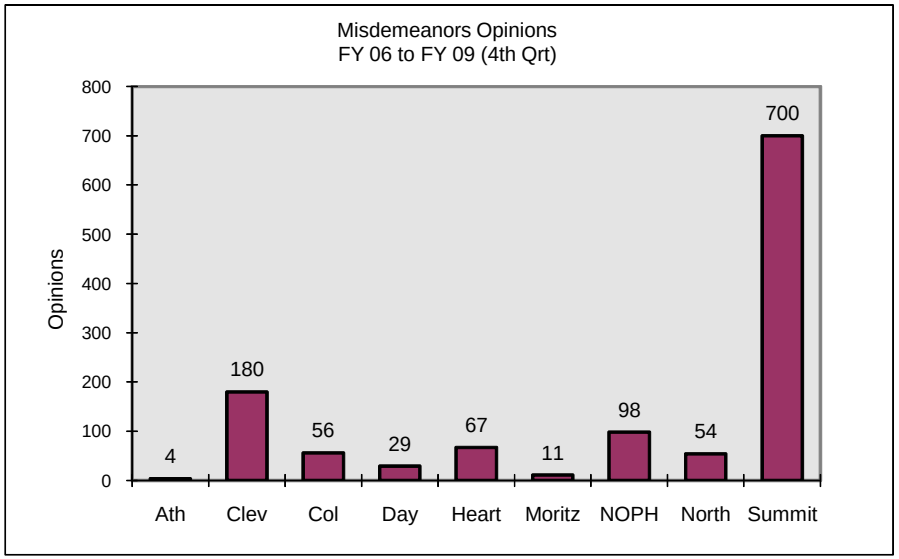
	Discharges				Median LOS			
Board	2006	2007	2008	2009	2006	2007	2008	2009
ALLEN-AUGLAIZE-HARDIN	4	6	6	4	69	58	264	100
ASHLAND	1	2	1	5	4	59	1	17
ASHTABULA	10	12	11	9	22	8	9	20
ATHENS-HOCKING-VINTON	20	18	23	25	18	8	14	17
BELMONT-HARRISON-MONROE	12	33	30	30	9	15	12	10
BROWN	1	2	2	3	63	126	13	122
BUTLER	27	22	33	21	74	97	123	59
CLARK-GREEN-MADISON	16	11	27	7	86	57	50	142
CLERMONT	6	7	7	11	97	94	220	112
COLUMBIANA	2	3	5	4	44	19	48	72
CUYAHOGA	236	210	219	258	65	57	70	79
DEFIANCE-FULT-WILL-HENRY	6	2	3	6	104	14	83	41
DELAWARE-MORROW	7	6	5	7	209	82	216	128
ERIE-OTTAWA	6	9	8	7	27	30	105	32
FAIRFIELD	15	9	9	10	31	23	338	17
FRANKLIN	119	96	101	102	62	81	91	74
GALLIA-JACKSON-MEIGS	26	18	14	16	7	10	7	9
GEAUGA	1	1	2	1	102	275	318	220
HAMILTON	301	308	297	178	61	66	57	64
HANCOCK	1		4	1	901		32	122
HURON	2	4	3	2	155	52	77	559
JEFFERSON	5	1	2	1	18	378	106	9
LAKE	9	7	12	10	57	91	83	163
LICKING-KNOX	13	12	13	12	27	62	210	112
LOGAN-CHAMPAIGN	5	5	6	1	8	15	43	105
LORAIN	9	8	23	21	119	153	125	87
LUCAS	103	90	76	76	36	31	40	49
MAHONING	28	34	26	20	157	80	80	53
MARION-CRAWFORD	3	1	2	2	20	85	89	74
MEDINA	4	2	7	6	20	245	22	6
MIAMI-DARKE-SHELBY	16	20	18	12	11	20	25	31
MONTGOMERY	73	83	100	36	67	58	162	124
MUSKINGUM	42	37	25	21	7	11	12	20
PORTAGE	8	8	6	12	26	31	44	16
PREBLE	3	8	2	1	3	12	16	83
PUTNAM	1	1	1		61	43	3	
RICHLAND	3	8	4	5	148	25	95	20
ROSS-PICK-PIKE-FAY-HIGH	17	12	8	17	33	116	153	95
SCIOTO-ADAMS-LAWRENCE	13	22	14	9	19	27	34	65
SENECA-SANDUSKY-WYANDOT	5	5	4	8	47	49	232	19
STARK	40	31	34	47	21	24	29	48
SUMMIT	60	50	29	49	92	118	115	108
TRUMBULL	4	9	8	11	85	187	91	26
TUSCARAWAS-CARROLL	7	4	4	6	55	328	318	79
UNION	2	3	3		69	16	13	
VANWERT-MERCER-PAULDING	1	3	6	4	20	32	27	20
WARREN-CLINTON	13	11	21	12	93	60	75	16
WASHINGTON	3	7	7	4	36	9	102	43
WAYNE-HOLMES	19	16	11	12	10	11	7	8
WOOD	11	9	4	10	27	43	42	23
Total	1339	1286	1286	1132	55	55	60	59

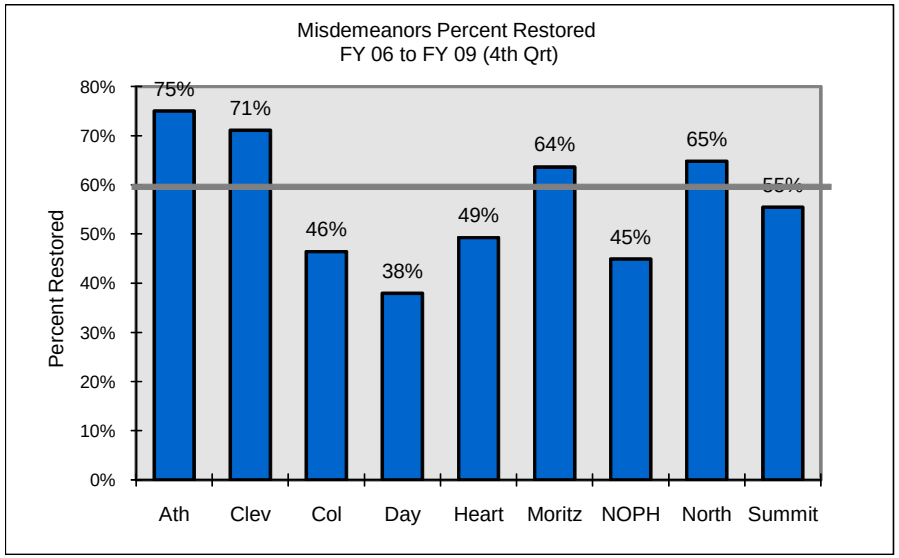
Misdemeanor Totals by Hospital

From FY 06 to FY 09 (4h Quarter)

	Opinions	Restored	Share of Total	% Restored
Athens	4	3	0%	75%
Cleveland	180	128	15%	71%
Columbus	56	26	5%	46%
Dayton	29	11	2%	38%
Heartland	67	33	6%	49%
Moritz	11	7	1%	64%
NOPH	98	44	8%	45%
Northfield	54	35	5%	65%
Summit	700	388	58%	55%
Total	1199	675		56%

Summit, which represents SW Ohio, comprises 58% of total misdemeanor cases.





Forensic Workgroup
October 19, 2009

Admission Rates at State Hospitals For Misdemeanor Restorations

During Fiscal Years 2008 and 2009

A Look at Repeated Stated Hospital Use by Recent Misdemeanor Cases

	Frequency	Percent
1st Admission to State Hospital	179	31%
1-2 Prior Admissions	151	26%
3-5 Prior Admissions	82	14%
6-10 Prior Admissions	72	13%
11 Plus Prior Admissions	87	16%

The number of "Repeat" hospitalizations associated with misdemeanor cases equals 392.

Of the total misdemeanor cases in the last two years – 69% have had repeated state hospital admissions.

Note: Prior hospitalizations comprise various civil and forensic legal statuses

Misdemeanor Restoration to Competency Discharges

For Fiscal Year 2009

Restoraton to Competency Discharges

Discharges	Median LOS	Total Bed Days	Total Cost
206	58	23208	$12,184,200

In Comparison . . . If patients were in acute care without forensic restoraton process.

Discharges	Acute Care LOS	Total Bed Days	Total Cost
206	13	2678	$1,405,950

Savings in Days	**20,530**
Savings in Dollars	**$10,778,250**

An example of a financial scenario:

Shows the savings if we could redirect misdemeanor cases to acute care treatment instead of the misdemeanor program

Note: Total cost based on a cost per day of $525

Misdemeanor Discharges with a Developmental Disabled Diagnosis

For FY 2009

Total Discharges	Dev Disabled Discharges	Percent
206	5	2%

Admission Rates at State Hospitals
For Misdemeanor Restorations
During Fiscal Years 2008 and 2009

A Look at Repeated Stated Hospital Use by
Recent Misdemeanor Cases

	Frequency	Percent
1st Admission to State Hospital	179	31%
1-2 Prior Admissions	151	26%
3-5 Prior Admissions	82	14%
6-10 Prior Admissions	72	13%
11 Plus Prior Admissions	87	16%

Admission Rates at State Hospitals
For Misdemeanor Restorations
During Fiscal Years 2008 and 2009

A Look at Repeated Stated Hospital Use by
Recent Misdemeanor Cases

ATHENS

	Frequency	Percent
1st Admission to State Hospital	2	67%
1-2 Prior Admissions	1	33%
3-5 Prior Admissions		
6-10 Prior Admissions		
11 Plus Prior Admissions		

HEARTLAND

	Frequency	Percent
1st Admission to State Hospital	9	27%
1-2 Prior Admissions	7	21%
3-5 Prior Admissions	7	21%
6-10 Prior Admissions	3	9%
11 Plus Prior Admissions	7	21%

TVBH Columbus

	Frequency	Percent
1st Admission to State Hospital	7	39%
1-2 Prior Admissions	4	22%
3-5 Prior Admissions	3	17%
6-10 Prior Admissions	3	17%
11 Plus Prior Admissions	1	6%

NBH CLEVELAND

	Frequency	Percent
1st Admission to State Hospital	31	34%
1-2 Prior Admissions	26	29%
3-5 Prior Admissions	16	18%
6-10 Prior Admissions	8	9%
11 Plus Prior Admissions	10	11%

TVBH Dayton (Closed - June 2008)

	Frequency	Percent
1st Admission to State Hospital	3	43%
1-2 Prior Admissions	1	14%
3-5 Prior Admissions	3	43%
6-10 Prior Admissions		
11 Plus Prior Admissions		

NBH NORTHFIELD

	Frequency	Percent
1st Admission to State Hospital	12	31%
1-2 Prior Admissions	12	31%
3-5 Prior Admissions	4	10%
6-10 Prior Admissions	4	10%
11 Plus Prior Admissions	7	18%

SUMMIT

	Frequency	Percent
1st Admission to State Hospital	109	32%
1-2 Prior Admissions	89	26%
3-5 Prior Admissions	45	13%
6-10 Prior Admissions	48	14%
11 Plus Prior Admissions	49	14%

NOPH

	Frequency	Percent
1st Admission to State Hospital	6	15%
1-2 Prior Admissions	11	28%
3-5 Prior Admissions	4	10%
6-10 Prior Admissions	6	15%
11 Plus Prior Admissions	13	33%

Misdemeanor Discharges with a Substance Abuse Diagnosis

For FY 2009

Total Discharges	Subst, Abuse Discharges	Percent
206	137	67%

Illustrating the Impact from the Diversion of Misdemeanor Cases

Shows the Potential Impact of Shifting 50% of Misdemeanor Cases to Acute Care Treatment
For Fiscal Year 2009

Restoraton to Competency Discharges

	Discharges	Median LOS	Total Bed Days	Total Cost
100% in Restoration Program	206	58	23208	$12,184,200

In Comparison . . . If fifty percent of the patients were diverted to acute care treatment without going through the forensic evaluation process.

	Discharges	Median LOS	Total Bed Days	Total Cost
50% in Acute Care Program	103	**13**	2575	$1,351,875
50% in Restoration Program	103	**58**	11604	$6,092,100

Potential Savings in Days	**9,029**
Potential Savings in Dollars	**$4,740,225**

Misdemeanor Calculation at 50%

Forensic Strategies Workgroup Report

Glossary

408 Line Item: A line item in the ODMH budget that contains funds distributed to ADAMH/CMH Boards for community mental health services and Board-purchased inpatient services for patients with a Non-Delayed/Billable status. From these funds ODMH retains a percentage for inpatient care for patients who have a forensic legal status (also designated as Delayed status/Non-Billable).

ADAMH/CMH Boards: There are 53 county behavioral health authorities in Ohio, including 47 Alcohol, Drug Addiction and Mental Health (ADAMH) Boards, 3 Community Mental Health (CMH) Board, and 3 Alcohol & Drug Addiction Services (ADAS) Boards. The boards are statutorily empowered to plan develop, fund, manage, and evaluate community-based mental health and substance abuse services. The federal, state, and local governments fund the Boards and in turn the Boards are responsible for ensuring the alcohol, drug addiction and/or mental health services are available to those who need them, regardless of their ability to pay.

Bed days: One bed day represents a bed in an ODMH Regional Psychiatric Hospital (RPH) that is occupied by one patient for one day.

Civil Inpatient Days: These are bed days in an ODMH hospital occupied by patients who have a nonforensic legal status and are committed to the hospital by the Probate Court pursuant to ORC Section 5122.01 *et seq* or who are voluntary.

Delayed Status (Non-Billable): These are patients in an ODMH hospital who have a forensic legal status and whose inpatient care is the financial responsibility of the state. These costs are not billed to the ADAMH/CMH boards. They are designated as a "delayed status" as a result of the Mental Health Act of 1988 in which the Boards delayed taking financial responsibility for the inpatient care of people with a forensic legal status.

Forensic Monitor: The Forensic Monitor is designated by the ADAMH/CMH Boards and is responsible to monitor persons found Not Guilty by Reason of Insanity (NGRI) and defendants found to be Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction (IST-U-CJ) on Conditional Release commitment. The Forensic Monitor or designee also serves as a forensic resource for CMH and ADAMH Boards, community mental health agencies, Forensic Centers, ODMH Regional Psychiatric Hospitals, and the criminal justice system. In collaboration with the Board, the monitor/designee provides education, training, consultation, liaison services, collects data and compiles required reports.

IST-R: Incompetent to Stand Trial—Restorable. ORC Section 2945.38. This refers to a person who has been found by a court to be incapable of understanding the nature and objective of the proceedings against him or her and unable to assist in his or her own defense. In addition the court has found that there is a substantial probability that the defendant will become competent to stand trial within one year if the defendant is provided with a course of treatment.

IST-U: Incompetent to Stand Trial—Unrestorable. ORC Section 2945.38. This refers to a person who has been found by a court to be incapable of understanding the nature and objective of the proceedings against him or her and unable to assist in his or her own defense. In addition the court has found that there is not a substantial probability that the defendant will become competent to stand trial within one year.

Mental Health Act of 1988: Legislation (Amended Substitute Senate Bill 156) passed in 1988 that firmly established the state's commitment to addressing the mental health needs of Ohioans through a unified system of community-based services. The law more fully defined the roles and responsibilities of the community mental health boards and the Ohio Department of Mental Health (ODMH) and updated and revised many areas of mental health law. More information is available at http://mentalhealth.ohio.gov/who-we-are/system-history/the-mental-health-act.shtml

NGRI: Not Guilty by Reason of Insanity. Defined in ORC Section 2901.01: "A person is 'not guilty by reason of insanity' relative to a charge of an offense only if the person proves, in the manner specified in section 2901.05 of the Revised Code, that at the time of the commission of the offense, the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts." The procedures governing the procedures following an NGRI finding by the court are described in ORC Section 2945.40.

Non-Delayed Status (Billable): These are patients in an ODMH RPH who have a civil commitment status or a limited number of forensic legal statuses and whose inpatient care is the financial responsibility of the state ADAMH/CMH boards. These costs are thus "billed" to the Boards. They are designated as a "non-delayed status" as a result of the Mental Health Act of 1988 in which the Boards took financial responsibility for the inpatient care of people with a civil commitment status or a limited number of forensic legal statuses.

Regional Forensic Centers/Certified Community Forensic Psychiatry Centers: There are eleven Community Forensic Psychiatric Centers that are certified by ODMH and provide forensic evaluation services for the criminal court system in Ohio, primarily Competency to Stand Trial and NGRI evaluations for Common Pleas Courts. They also provide second opinion evaluations for ODMH Regional Psychiatric Hospitals on patients being considered for nonsecured movement statuses. The Forensic Centers are located in various regions throughout the state and each provides services to designated counties. The Centers also provide consultation and training services for the local criminal justice system, the ADAMHS/CMH Boards and community mental health providers.