

2012 Forensic Manual

A resource for state and community systems
that serve people with mental illness
who are under the jurisdiction of the criminal courts

Ohio | Department of
Mental Health

Developed and distributed by the
Office of Forensic Services

30 East Broad Street • Columbus, OH • (614) 466-1099



Department of
Mental Health

John R. Kasich, Governor
Tracy J. Plouck, Director

Dear Colleague,

I am pleased to present the 2012 revision of the Ohio Department of Mental Health's *Forensic Manual*. During my tenure as director, I've observed many worthy initiatives by our department to improve the forensic system in full collaboration with various community stakeholders. Many of these efforts stemmed from recommendations of the Forensic Strategies Workgroup which completed its work in 2010. My hope is that the hard work of all those involved will be reflected in this revised manual and, more importantly, in the quality of care and services provided to individuals involved in the forensic system.

The last revision of this manual was in 2003; some highlights of the new material in this 2012 edition include:

- hyperlinks to documents and resources available on the internet;
- incorporation of the most recent legislative and policy changes; and
- discussion of recent improvements to the forensic mental health system.

I understand the complexity of this work, as well as the responsibility that ODMH and its partners have to assure public safety while encouraging and fostering recovery. It is imperative that people who work with forensic clients have available the most up-to-date resources possible. This manual should be a useful tool for reference, education and practical guidance when working with individuals in the forensic mental health system.

I would like to thank the individuals who participated in the development of the revised *Forensic Manual 2012*. It has taken the substantial time and dedication of many people to assure that it is accurate, helpful and a true reflection of policy, legislation and philosophy regarding services provided to individuals in the forensic system.

Sincerely,

Tracy J. Plouck
Director

Establishing mental health as a cornerstone of overall health

30 East Broad Street
Columbus, Ohio 43215
mentalhealth.ohio.gov

614 | 466-2596
614 | 752-9696 TTY
614 | 752-9453 Fax

ODMH FORENSIC MANUAL

2012 Edition

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OHIO FORENSIC MANUAL

2012 EDITION

INTRODUCTION

Purpose

The Ohio Department of Mental Health (ODMH) distributed the original Forensic Manual in 1980 and has issued several revisions since that time, most recently in 2003. Revisions were necessary as a result of developments in the forensic mental health system and new legislation. Since 2003, a number of changes have occurred that make an updated Forensic Manual essential.

The Forensic Manual is intended to provide education and practical direction to mental health service providers, administrators, courts, and other interested parties. It is a resource guide regarding issues related to people involved in the forensic mental health system.

The 2012 edition of the Ohio Forensic Manual includes a number of improvements and updates including revisions to information published previously in this Manual, coverage of new initiatives involving the forensic mental health system in Ohio, and the inclusion of hyperlinks to a variety of ODMH and external documents that are referenced in the Manual. Although the previous edition was available online, this Manual is intended to be distributed primarily as an electronic document.

As in the previous edition of the Forensic Manual, this edition includes descriptions of the ODMH inpatient system plus additional components of the system, such as the [Community Forensic Psychiatry Centers](#), the Criminal Court system, the [Community Forensic Monitoring Program](#), the [Community Linkage Program](#), Mental Health Diversion Alternatives, and several new programs and initiatives. Policies, procedures, guidelines and other documents that are referenced in the Manual are contained in the Appendix and hyperlinked to their source where available.

This manual is prepared by the Office of Forensic Services (OFS) but it was produced through collaboration with stakeholders from ODMH Regional Psychiatric Hospitals (RPH) and representatives from the Community Forensic Monitors and Community Forensic Psychiatry Centers. OFS would like to thank all those who helped in the revision of this Manual.

Recent History and Trends

Since the 1980's, the Office of Forensic Services has striven to provide services to individuals with a forensic legal status in the least restrictive treatment alternative available that is consistent with public safety and the welfare of the individual. An array of inpatient and outpatient services have been developed during this time resulting in improved violence risk assessment and risk management practices, implementation of more standardized policies and procedures, and better communication/coordination between hospitals and community providers. Providing these services has become increasingly challenging in recent years due to reduced resources.

As a result of the increasing proportion of people in ODMH RPHs with a forensic legal status, a Forensic Strategies Workgroup was formed in 2009 in order to propose strategies that would more effectively and efficiently provide these services. This workgroup produced a [report](#) in

January 2010 that included eight strategies dealing with a variety of issues such as revised funding mechanisms, new diversionary measures, forming new partnerships to work with underserved populations, increased consultation with, and education of, various stakeholders, and increasing the efficiency within the forensic mental health system. At this time, work on the implementation of these strategies is continuing.

The Ohio Forensic Mental Health System

The Ohio Forensic Mental Health System is made up of components from various systems. These components include the [ODMH Regional Psychiatric Hospitals](#) (RPH; see [Appendix A](#)), [Community Forensic Psychiatry Centers](#), [Community Forensic Monitors](#), ODMH central office staff, representatives from the Judicial System, staff from Alcohol, Drug Addiction, & Mental Health Services/ Community Mental Health (ADAMHS/CMH) boards, community mental health agencies/providers, and private psychiatric hospitals. These entities work together to form a comprehensive forensic mental health system. Additional information regarding these components and their roles in the system will be found within this Manual.

OVERVIEW OF THE OHIO DEPARTMENT OF MENTAL HEALTH SYSTEM

There are currently six ODMH-operated Regional Psychiatric Hospitals (see [Appendix A](#)). Each RPH provides inpatient psychiatric services for adults who are civil and forensic admissions. Also, through Community Support Network (CSN) Adult teams, RPH staff provide community-based mental health services to adults. The Department works in coordination with the ADAMHS and CMH Boards to ensure that persons with mental illness in the community receive quality mental health services. The ADAMHS and CMH Boards are responsible for the planning, funding, monitoring and oversight of the community service system. The Boards contract with the ODMH RPHs and private hospitals to provide inpatient services, and with the ODMH-operated CSN programs for outpatient services.

ODMH Inpatient Forensic and Risk Management Services

At the end of Fiscal Year 2002, there were a total of 606 forensic patients on rolls, which represented 54% of the total ODMH inpatient population of 1121. In contrast, at the end of Fiscal Year 2011, there were a total of 603 forensic patients on rolls, which represented 67% of the total ODMH inpatient census of 901. Each RPH serves designated counties (see [Appendix B](#)) by providing services to persons admitted in the following forensic categories: Incompetent to Stand Trial—Restoration Treatment (IST-R), Incompetent to Stand Trial—Unrestorable (Probate Court Jurisdiction; IST-U-PJ), Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction (IST-U-CJ); Not Guilty by Reason of Insanity acquittees (NGRI), Sanity/Competency Evaluations, Mentally Ill Probationers/Parolees, Jail Transfers, Police Holds and Conditional Release admissions.

The ODMH Hospital Services system provides two levels of care in civil and maximum security settings. Historically, the RPH's civil units provided services to individuals in a voluntary admission status or those who were committed through the Probate Court as a civil admission. Currently, forensic and civil status patients are integrated on these units. The Department's Maximum Security Unit, Timothy B. Moritz Forensic Unit, is located at Twin Valley Behavioral Healthcare (TVBH) in Columbus. The Maximum Security Unit provides a higher level of security and allows for patient movement to be safely managed within the confines of the facility.

The RPH staff monitor patients for violence risk through regularly-conducted clinical risk assessments and through the development of treatment plans to manage identified risks. Since forensic status patients generally present higher risk, movement and privileges are restricted, and in some cases require the trial court's approval. Special risk management procedures are followed for certain forensic patients in the hospitals. (See [Appendix C](#), Risk Assessment Policy, MF-03). In 2009, ODMH hospitals adopted the HCR-20 (Historical, Risk, Clinical Management-20) as the basis for violence risk assessments. The ODMH policy "Movement of Patients Committed under a Forensic Status" (MF-04, [Appendix D](#)) identifies who is eligible for movement based on the patient's legal status. An increase in movement level requires a recommendation from the patient's treatment team, an internal review of the patient's clinical condition, consideration of the original and updated risk assessments, and for many individuals, review by the RPH Forensic Review Team (FRT) and the approval of the Chief Clinical Officer (CCO). The RPH is required to request a Nonsecured Status ("Second Opinion") evaluation, performed by the local Community Forensic Psychiatry Center, prior to recommending that the trial court approve an increase in movement level to Nonsecured Status for some forensic status patients. The system was established to allow for a series of checks and balances to decrease risk and increase quality clinical care.

The RPH treatment staff, the community treatment provider, and when applicable, the community Forensic Monitor, work together to coordinate services when a person with mental illness is involved in the court system. Generally, this begins prior to the time when an individual is preparing for hospital discharge. Forensic patients who are eligible for Conditional Release are involved in the development of their conditional release plan with the RPH treatment staff, the Forensic Monitor, and the community treatment providers. The conditional release plan identifies the terms or conditions that the person agrees to abide by while on conditional release commitment and while being monitored by the Forensic Monitor, the community treatment provider, and the Criminal Court. The community mental health service providers may be part of a community mental health center or a Community Support Network (CSN) program. The CSN teams work in the community to provide services and are employed by ODMH.

A more detailed description of inpatient forensic services is provided in this Manual in the section titled [Ohio Department of Mental Health Forensic Inpatient Services](#).

Office of Forensic Services

The Office of Forensic Services (OFS) administers, supports and manages the system of services provided to people with mental illness involved in the criminal justice system in Ohio. OFS staff work with ADAMHS/CMH Boards, community agencies, RPHs, other state agencies, judges and criminal justice system staff, and various state legislators on issues that impact the forensic population. OFS is an office within the Division of Program and Policy Development. This office works with other ODMH offices on issues that affect the forensic population and providers in the community and RPH settings. A forensic newsletter is published to keep the hospitals, community boards and agencies, courts, and other stakeholders informed of legal changes and other forensic issues.

The Office of Forensic Services is made up of four functional areas: (a) Community Linkage, (b) RPH/Community Mental Health Services, (c) Mental Health Diversion Alternatives, and (d) Community Monitoring Program.

The *Community Linkage Program* was developed by ODMH in coordination with the Ohio Department of Rehabilitation and Correction (ODRC) as a response to an identified need. The primary purpose of the Community Linkage Program is the improvement of continuity of mental health care for offenders entering and leaving the prison system.

The Community Linkage Program, under the supervision of the Chief of the Office of Forensic Services, consists of a Community Linkage Manager (CLM) and Community Linkage Social Workers (CLSWs). The duties of the CLM include supervision of the CLSWs, collaboration and liaison with the area Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards or Community Mental Health (CMH) Boards and other stakeholders on linkage procedures, and program coordination with the prisons, jails, psychiatric hospitals, and community mental health and substance abuse service providers within their areas. Each ODRC prison has an assigned/designated CLSW who is responsible for providing linkage services to that prison's mental health. More detailed information regarding this program is provided on page 46.

The *RPH/Community Mental Health Services* function of the office works with the ODMH Regional Psychiatric Hospitals (RPH), Community Forensic Psychiatry Centers, ADAMHS/CMH Boards, and community mental health agencies to develop consistent and effective forensic evaluation and treatment practices. OFS staff work with various constituencies to develop policies and programs, share concerns, and make recommendations for improvement. They assist in the review and development of policies, procedures, and guidelines for inpatient psychiatric services for those persons who are committed to ODMH RPHs by the Criminal Courts, in part through their oversight of the Forensic Service Line. These staff also work with local communities to develop locally-managed systems of care for persons in the community with a forensic status. Staff provide training, work in conjunction with the ODMH Legislative Liaison regarding forensic legislation, and coordinate the certification of Community Forensic Psychiatry Centers with the Office of Licensure and Certification.

The Office of Forensic Services' *Mental Health Reentry and Diversion Alternatives* function promotes jail diversion and reentry programs for persons with mental illness through several means. One of these includes directing the Criminal Justice Coordinating Center of Excellence (CJ-CCOE). The mission of the CCOE is to promote the adoption of evidence-based practices in jail diversion around Ohio. OFS encourages and supports improved consumer outcomes through collaboration of the mental health and criminal justice systems. At the national, state and local levels, OFS staff members participate in advisory boards, work groups, and committees, providing input and guidance leading to improved systems development. ODMH Office of Forensic Services also seeks grants and may issue grants for reentry/diversion projects as appropriate. More detailed information is provided on page 58.

Through the *Community Monitoring Program* function, OFS gathers data from the community Forensic Monitors and ADAMHS/CMH Boards in order to monitor and evaluate the effectiveness of community forensic programs. One of these programs involves the Forensic Tracking and Monitoring System. This database was established in 1997 pursuant to section 5119.57 of the Revised Code, which calls for "a coordinated system for tracking and monitoring persons" who have been placed on Conditional Release by the Court. Various outcomes, including arrests, revocations, and hospitalizations are tracked through this system. More information about the Forensic Monitoring Program may be found on page 46.

THE CRIMINAL COURTS OF OHIO

Portions of this section have been reprinted, with permission and with some modification, from *The Manual of the Ohio Forensic Psychiatry Centers*.

The Criminal Courts of Ohio are the primary consumers of the work product of all Community Forensic Psychiatry Centers. Therefore, every forensic examiner should know the judicial context within which he/she is operating and have some understanding of the court system and its functioning. The following is a concise description of the Ohio Criminal Court System.

Article IV, Section Four, Section A of the [Ohio Constitution](#) provides for the establishment of Common Pleas Courts in each of Ohio's counties. Section [2931.03](#) of the Ohio Revised Code gives “inferior” courts such as Municipal or County Courts jurisdiction in misdemeanor cases, whereas felony cases remain in Common Pleas Courts. Courts of Common Pleas also have jurisdiction in civil cases (torts) and have divisions that handle probate, domestic relations, and juvenile matters.

Jurisdiction

“Jurisdiction” is defined as: “That power conferred on a court by law by which it is authorized to hear, determine, and render final judgment in an action and to enforce its judgment by legal process.” There are four types of jurisdiction:

1. **Exclusive Jurisdiction**
Exclusive Jurisdiction is seen in some functions of the Juvenile Court. If a juvenile commits a crime, the Juvenile Court retains jurisdiction, unless it elects to give it up.
2. **Original Jurisdiction**
Original Jurisdiction is assigned to the court that first encounters a problem. This most commonly occurs when a felony is committed within a city. The Municipal Court has initial jurisdiction but cannot take the case to completion.
3. **Concurrent Jurisdiction**
Concurrent Jurisdiction occurs when two courts are involved in a single issue. For example, both the Domestic Relations Court and Juvenile Court have an interest when someone is charged with nonsupport.
4. **Final Jurisdiction**
Final Jurisdiction refers to the power of a court to make final orders and dispose of cases. Common Pleas Courts in Ohio have final jurisdiction in felonies.

Types of Charges, Bail, and Bond

“Crime” may be defined as: “A forbidden act (*actus reus*) committed with evil intent (*mens rea*).” If a crime is committed within a city, the matter will be taken up in Municipal Court after an arrest is made. If the crime was not committed in a city, it will be taken up in the County District Court. If the matter is a misdemeanor (maximum penalty six months or less), the lower

court has final jurisdiction. If the crime is a felony (maximum sentence is in excess of six months), the lower court has only original jurisdiction.

A person charged with a felony has a preliminary arraignment in the lower court. At this step, the defendant is informed of the charge, enters a plea, and has bail set. An amendment of Section 9 Article I of the Constitution of the State of Ohio provides that a court may deny bail to a person who is charged with a felony offense where the proof is evident or the presumption great that the person committed the offense and the court also determines that the person poses a substantial risk of serious physical danger to others. The General Assembly is to establish standards to determine when a person poses a substantial risk and the court is to determine the type, amount and conditions of bail in these cases.

The Ohio Constitution guarantees a person the right to bail that is not excessive. The court sets the bail based on the information it has on hand and any additional facts gathered from an outside investigation of the accused.

There are three basic types of bail used in Ohio. A person may be released on his own recognizance (referred to as "O.R."), which means the person is taken at his word that he will reappear when ordered. Conditions such as calling the court weekly can also be added to this type of bond. A case bond may be required, which means a certain amount of money must be posted to guarantee future appearances. If the persons fail to appear, the state takes the money. An example of this is when a court sets a \$10,000 bond. The accused or his family may post that amount or go to a bondsman. The bondsman would receive 10 percent or \$1,000 and then advise the clerk that he will post the entire amount of the bond. The bondsman retains the 10 percent as his commission. Should a person be found not guilty, the bondsman still retains the money for the service of posting the additional amount.

The courts in Ohio have adopted a so-called "Ten-Percent (bond) Provision" for several reasons (financial hardships and unscrupulous activity by bondsmen). This provision specifies that for a \$10,000 bond the accused or his family can post 10% or \$1,000 with the clerk of courts. If the person appears as ordered, 90% (\$900 in this instance) is returned to the person who posted it, regardless of the outcome.

Preliminary Hearings, Arraignments, and Pre-trial Conferences

The next step for a person accused of a felony is a preliminary hearing, which is again held in the lower court. At this hearing, the state must show "probable cause" that a crime was committed and that the accused person committed the crime. This step may be waived by the accused. In the past, the defense often used the preliminary hearing to learn what evidence was in the state's possession. However, the rules of discovery make this purpose much less important. If "probable cause" is found at a preliminary hearing, the accused is bound over to the county grand jury. Here, the jurisdiction of the Common Pleas Court begins. The issue of competency to stand trial may be raised at this time.

The grand jury is a panel of fifteen citizens (a minimum of nine is constitutionally permissible) who meet in secret and hear only the evidence presented by the state. An accused person can testify before the grand jury only if he or she is subpoenaed. The jury votes after hearing the evidence presented by the state. Twelve of the fifteen members must vote to indict or return a "true bill" for the person to be charged with a crime. If the required twelve or more do not vote

to indict, the case is considered “ignored” by the grand jury and the matter is dropped. In reality, the vast majority of cases presented to the grand jury by the prosecutor result in indictment. The indictment citing the violation of the law is then given to the sheriff of the county to be delivered to the person indicted. The indictment includes a time and place for the person to appear in Common Pleas Court for a second arraignment.

At this arraignment, the defendant has the right to have the indictment read to him or her (usually waived); he or she must have had the indictment “served” on him or her at least a day earlier. Bond is either continued from the lower court or a new bond is set. The defendant must then enter a plea or the defendant can stand mute, and the court will enter a plea for the person. The following pleas could be tendered: Not Guilty, Guilty, Former Judgment of Conviction on Acquittal, Former Jeopardy, Not Guilty by Reason of Insanity, Nolo Contendere (No Contest), or Plea of Abatement. The third and fourth pleas relate to the person having already been adjudicated for the same matter. The last plea would indicate the court does not have jurisdiction, for example, if the defendant was a juvenile. A No Contest plea indicates the defendant will make no defense or admission regarding the offense; it almost always results in a guilty finding. The lack of admission is important in vehicular homicides where there will be a civil suit. The plea of Not Guilty by Reason of Insanity, which questions the defendant's sanity at the time of the alleged offense, facilitates a referral to an examiner, most often at a Community Forensic Psychiatry Center for an evaluation. In reality, the vast majority of defendants enters a plea of Not Guilty and asks for a pre-trial conference. The defendant's right to counsel was expanded by the [*Gideon vs. Wainwright*](#) decision of 1963, which guaranteed counsel for indigent defendants.

The judge is usually present at the pre-trial conference between the prosecutor and defense attorneys but does not take an active part. Although Section 5, Article 1 of the Ohio Constitution guarantees the defendant's right to a jury trial, the pre-trial conference often results in a negotiated plea of Guilty—either as charged in the indictment or to a lesser offense. This practice, commonly referred to as “plea bargaining,” has been constantly debated in legal circles, although the provisions of negotiated pleas are now more open and part of the case record. In Ohio, at least three-quarters of all indictments end with a negotiated plea of Guilty. If a negotiated plea is not determined, the case can be dismissed (the prosecutor would file a *nolle prosequi*) or the matter would be set for trial.

Competency to Stand Trial

A defendant is presumed to be competent to stand trial. A defendant may be found incompetent to stand trial, if, by a preponderance of the evidence, because of the defendant's present mental condition, the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense.

If the court, prosecutor, or defense attorney raises the question about the defendant's competency to stand trial, the court may request that a competency evaluation be completed by a Community Forensic Psychiatry Center within 30 days.

If the issue of a defendant's competence to stand trial is raised, the court may order one or more evaluations of the defendant's present mental condition. If the court orders more than one evaluation for competency, the prosecutor and the defendant may recommend to the court an examiner whom each prefers to perform one of the evaluations. If the court does not designate a second examiner recommended by the defendant, the court shall inform the defendant that the

defendant may have independent expert evaluation and that if the defendant is unable to obtain independent expert evaluation, it will be obtained for the defendant at public expense if the defendant is indigent.

Pursuant to section [2945.37\(B\)](#) of the Revised Code, in a criminal action in a Court of Common Pleas, a County Court, or a Municipal Court, the court, prosecutor, or defense may raise the issue of the defendant's competence to stand trial. If the issue is raised before the trial has commenced, the court shall hold a hearing on the issue of the defendant's competence within thirty days after the issue is raised, unless the defendant has been referred for evaluation, in which case the court shall conduct the hearing within ten days after the filing of the evaluation report. If the issue is raised after the trial has commenced, the court shall hold a hearing on the issue only for good cause shown or on the court's own motion.

The completed competency report is sent to the court who then determines if the defendant is competent or incompetent to stand trial. No statement that a defendant makes in a competency evaluation or hearing under section [2945.371](#) (A) through (H) of the Revised Code shall be used against the defendant on the issue of guilt in any criminal action or proceeding. In a criminal action or proceeding, the prosecutor or defense counsel may call as a witness any person who evaluated the defendant or prepared a report pursuant to a referral under this same section.

If the defendant is found competent then the trial would proceed as usual.

If the examiner's report suggests that the defendant is not competent and appears to be a mentally retarded person subject to institutionalization by court order, the court may also order a defendant, pursuant to section [2945.371\(H\)](#) of the Revised Code, to have a separate mental retardation evaluation. In this case, the hearing shall occur within ten days after the filing of the report of the separate mental retardation evaluation.

If it is determined that the defendant is not competent but restorable to competency, the court then determines the least restrictive environment where the defendant could be restored. The forensic examiner is to make a recommendation in his/her report as to the least restrictive treatment alternative. In many cases that setting would be an ODMH Regional Psychiatric Hospital (RPH) although in some cases outpatient competency restoration is appropriate and available. The maximum length of treatment for restoration of competency is related to the severity of the offense charged. (see [Appendix E](#))

If the defendant is restored to competency, a trial or plea negotiation will usually follow. In some cases, the charges may be dismissed by the prosecutor. If the defendant is not restored, there are different procedures to follow that are covered in the Revised Code ([2945.38](#) – [2945.402](#)).

Not Guilty by Reason of Insanity

A person is "not guilty by reason of insanity" (NGRI) relative to a charge of an offense only if the person proves, by a preponderance of the evidence, that at the time of the commission of the offense, the person did not know, as a result of severe mental disease or defect, the wrongfulness of the person's acts. Proof that a person's reason, at the time of the commission of an offense, was so impaired that the person did not have the ability to refrain from doing the act(s), does not constitute a defense (R.C. [2945.391](#)). Only the defense may enter a plea of not guilty by reason

of insanity. If this issue is raised, an evaluation would be ordered by the court to be completed by a Community Forensic Psychiatry Center or other examiner within 30 days.

Pursuant to section [2945.371\(A\)](#) of the Revised Code, the court may order one or more evaluations of the defendant's mental condition at the time of the offense charged. If the court orders more than one evaluation for sanity, the prosecutor and the defendant may recommend to the court an examiner whom each prefers to perform one of the evaluations. If the defendant enters a plea of not guilty by reason of insanity and the court does not designate an examiner recommended by the defendant, the court shall inform the defendant that the defendant may have independent expert evaluation and that if the defendant is unable to obtain independent expert evaluation, it will be obtained for the defendant at public expense if the defendant is indigent.

No statement that a defendant makes in a sanity evaluation or hearing under section [2945.371](#) (A) through (H) of the Revised Code shall be used against the defendant on the issue of guilt in any criminal action or proceeding. In a criminal action or proceeding, the prosecutor or defense counsel may call as a witness any person who evaluated the defendant or prepared a report pursuant to a referral under this same section.

If the court determines that the defendant knew the wrongfulness of his actions and was not suffering from a severe mental disease or defect as defined in section [2901.01\(A\)\(14\)](#) of the Revised Code the trial would proceed. If it is determined that the defendant is NGRI the trial court shall conduct a full hearing—within ten court days after the finding of not guilty by reason of insanity—to determine whether the person is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, pursuant to section [2945.40](#) of the Revised Code. There are then three things that can happen: (1) the NGRI acquittee may be discharged if he/she does not meet criteria as a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order; (2) if at least one of the above criteria are met, the person may be (a) hospitalized or institutionalized with an appropriate level of security immediately (or at a later date); or (b) discharged and granted conditional release. The period of commitment shall not exceed the maximum term of imprisonment for the single most serious charge that could have occurred if the person was convicted. (See [Procedures Following a Finding of Not Guilty by Reason of Insanity](#))

Trial and Post-Conviction

A defendant has a right to a trial by a jury of his peers, a trial before a judge or, in a capital offense, a trial by a three-judge panel. Upon granting a defendant's motion for forensic evaluation, the trial court usually tolls (i.e., stops) the running of the Speedy Trial Statutes, sections [2945.71](#), [2945.72](#), and [2945.73](#) of the Revised Code, for the time it takes to complete the evaluation.

If the defendant is found guilty or has pled guilty through a negotiated plea, the court will often refer the case to the probation department for a presentence investigation. The final disposition options are incarceration, probation, or judicial release. If the individual is sentenced to prison he or she may eventually be placed on Post Release Control, Transitional Control or may be released after serving a fixed or maximum sentence.

At any point in the proceeding, a defendant in custody has the basic right to file a petition of Habeas Corpus. This process determines the legality of the restraint or custody under which a person is held. Due to the flood of petitions filed by incarcerated inmates in court, Ohio instituted a system of Post-Conviction Relief (R.C. [2953.21](#)), which gives the question of release back to the sentencing court.

COMMUNITY FORENSIC PSYCHIATRY CENTERS

Introduction

There are currently ten Community Forensic Psychiatry Centers providing forensic evaluation services for the Criminal Court system in Ohio. They also provide Nonsecured Status or “Second Opinion” evaluations for the ODMH Regional Psychiatric Hospitals (RPHs) on patients being considered for Nonsecured Status (Level 5, Trial Visit or Conditional Release).

The Forensic Centers are located in various regions throughout the state and each provides services to designated counties. Prior to the development of the current system, most court-ordered sanity and competency evaluations occurred on an inpatient basis at one location. The Forensic Center system was developed to allow for the local provision of evaluations on an outpatient basis. This decreases the cost of the evaluation process, and reduces delays in court proceedings. The centers provide timely, comprehensive, and professional evaluations locally, eliminating the stigma of inpatient hospitalization and increasing cost effectiveness.

The Forensic Centers also provide consultation and training services for the local criminal justice system, the [ADAMHS/CMH Boards](#), and community mental health agencies. As part of the community forensic mental health system, the centers assist the boards and community mental health agencies in identifying the needs of this population for program and service planning purposes. In addition, the staff of these centers provide expert testimony for their local courts.

Each of the Forensic Centers is required to be certified as a mental health agency to provide forensic evaluation services and to be a certified Community Forensic Psychiatry Center. The certification process, performed by the Office of Licensure and Certification and the Office of Forensic Services of ODMH ensures compliance with the requirements of Administrative Rules [5122-29-07](#) regarding Forensic Evaluation Service and [5122-32-01](#) on Community Forensic Psychiatry Centers.

The organizational structure of each of the Forensic Centers varies throughout the state, although each is required to be either a free standing organization or a specifically designated subdivision of a larger organization. Each center is required to have a mission statement, a table of organization that clearly delineates the authority and responsibility of all staff, and a description of the services provided to Criminal Courts. The centers employ qualified examiners, pursuant to the requirements defined in section [2945.37](#) (A)(2) of the Revised Code.

In 1974, the directors of the Community Forensic Psychiatry Centers in Toledo, Dayton, and Columbus began meeting informally to discuss policies, procedures, and problems. This group was expanded as more centers were established, eventually evolving into the Association of the Ohio Forensic Psychiatric Center Directors. The goals of this organization include sharing of information, planning and sponsoring educational events, maintaining quality standards, monitoring legislative activity, and advocating for shared concerns.

Competency to Stand Trial Evaluation Services

One function of the Community Forensic Psychiatry Centers is to provide competency to stand trial evaluation services for the local courts. For details regarding criminal court processes and

procedures relevant to the issue of a defendant's competence to stand trial, please see the [Competency to Stand Trial](#) segment in the Criminal Courts of Ohio section of this document .

The purpose of an evaluation of a defendant's competency to stand trial is to determine whether the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense.

Competency evaluations shall be conducted by an "examiner," as defined in section [2945.37\(A\)\(2\)](#) of the Revised Code.

The court shall inform the examiner of the offense with which the defendant is charged.

When the court orders an evaluation, the defendant is required to be available at the times and places established by the examiner(s) conducting the evaluation under section [2945.371\(C\)](#) of the Revised Code. The court may order a defendant who has been released on bail or recognizance to submit to an evaluation. If a defendant who has been released on bail or recognizance refuses to submit to a complete evaluation, the court may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver the defendant to an ODMH facility, or a Department of Developmental Disabilities ([DODD](#)) facility where the defendant may be held for evaluation for a reasonable period of time not to exceed 20 days¹. A County or Municipal Court judge may commit the defendant for an inpatient evaluation only upon the request of an examiner from a certified Community Forensic Psychiatry Center. (See R.C. [2945.37 \[H\]](#) and R.C. [2945.371 \[D\]](#)).

The examiner shall file a written report with the court within 30 days¹ after the entry of a court order for the evaluation. The court shall provide copies of the report to the prosecutor and defense counsel. The report shall include all of the following:

1. The examiner's findings;
2. The facts in reasonable detail on which the findings are based;
3. Whether the defendant is capable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's own defense;
4. If the defendant does *not* meet the criteria in (3) above, whether the defendant is presently mentally ill or mentally retarded and, if the examiner's opinion is that the defendant is presently mentally retarded, whether the defendant appears to be a mentally retarded person subject to institutionalization by court order;
5. A prediction from the examiner as to the likelihood of a defendant assessed as incompetent to become capable of understanding the nature and objective of the proceedings against the

¹ In the Revised Code, the word "days" means calendar days unless the law specifically uses the words "court days." However, if the final day of a period falls on a weekend or holiday, then the final day is the next business day.

defendant or of assisting in the defendant's defense within one year² if the defendant is provided with a course of treatment.

6. If the examiner's opinion is that the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense and that the defendant presently is mentally ill or mentally retarded and likely to be restored within a year, the examiner's recommendation as to the least restrictive treatment alternative, consistent with the defendant's treatment needs for restoration to competency and with the safety of the community.

No conclusory statement is required about the defendant's competence to stand trial.

An examiner appointed under section [2945.371](#) of the Revised Code to evaluate the defendant's competence to stand trial may also be appointed to evaluate a defendant who has entered a plea of not guilty by reason of insanity (i.e., a sanity evaluation). The examiner shall prepare separate reports on the issue of competence to stand trial and the defense of not guilty by reason of insanity. If an examiner assesses the defendant as not meeting the criteria for competency to stand trial, the examiner should not prepare a report regarding sanity until the defendant is restored to competency.

Sanity Evaluation Services

The Community Forensic Psychiatry Centers also provide sanity/criminal responsibility evaluation services for the local court system.

For details regarding criminal court processes and procedures relevant to the issue of entering a plea of not guilty by reason of insanity—and being evaluated for eligibility for an NGRI plea—please see the [Not Guilty by Reason of Insanity](#) segment in the Criminal Courts of Ohio section of this Manual.

The purpose of a sanity evaluation is to determine whether the defendant did not know, at the time of the offense charged, as a result of a severe mental disease or defect, the wrongfulness of the defendant's acts charged. (R.C. [2901.01 \[A\]\[14\]](#)).

Also, according to section [2901.21\(C\)](#) of the Revised Code, “voluntary intoxication may not be taken into consideration in determining the existence of a mental state that is an element of a criminal offense. Voluntary intoxication does not relieve a person of a duty to act if failure to act constitutes a criminal offense.”

The evaluation shall be conducted by an “examiner,” as defined in section [2945.37\(A\)\(2\)](#) of the Revised Code.

The court shall inform the examiner of the offense with which the defendant is charged.

² A defendant may be required to undergo treatment for the purpose of restoration of competency to stand trial for a period of thirty days to one year, depending upon the severity of the offense, pursuant to section [2945.38\(C\)](#) of the Revised Code.

When the court orders an evaluation, the defendant is required to be available at the times and places established by the examiner(s) conducting the evaluation under section [2945.371\(C\)](#) of the Revised Code. The court may order a defendant who has been released on bail or recognizance to submit to an evaluation. If a defendant who has been released on bail or recognizance refuses to submit to a complete evaluation, the court may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver the defendant to an ODMH facility or a Department of Developmental Disabilities ([DODD](#)) facility where the defendant may be held for evaluation for a reasonable period of time not to exceed twenty days. A County or Municipal Court judge may commit the defendant for an inpatient evaluation only upon the request of an examiner from a certified Community Forensic Psychiatry Center. (See R.C. [2945.37 \[H\]](#) and [2945.371 \[D\]](#)).

In conducting an evaluation of a defendant's mental condition at the time of the offense charged, the examiner shall consider all relevant evidence. According to section [2945.392](#) of the Revised Code, if the offense charged involves the use of force against another person, the relevant evidence to be considered includes, but is not limited to, any evidence that the defendant suffered, at the time of the commission of the offense, from "battered woman syndrome."

The examiner shall file a written report with the court within thirty days after the entry of a court order for evaluation and the court shall provide copies of the report to the prosecutor and defense counsel. The report shall include all of the following:

1. The examiner's findings;
2. The facts in reasonable detail on which the findings are based;
3. Whether the defendant, at the time of the offense charged, did not know, as a result of a severe mental disease or defect, the wrongfulness of the defendant's acts charged pursuant to section [2901.01\(A\)\(14\)](#) of the Revised Code.

An examiner appointed under section [2945.371](#) of the Revised Code to evaluate a defendant who has entered a plea of not guilty by reason of insanity may also be appointed to evaluate a defendant's competence to stand trial. The examiner shall prepare separate reports on the issue of competence to stand trial and the defense of not guilty by reason of insanity (NGRI). If an examiner assesses the defendant as not meeting the criteria for competency to stand trial, the examiner should not proceed with the sanity (NGRI) report until the defendant is restored to competency.

Post-NGRI Evaluation Services

The purpose of a Post-NGRI evaluation is to assist the court in determining whether the person is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, pursuant to sections [2945.40 \(A\) and \(B\)](#).

A hearing to determine the most appropriate placement and level of security necessary for the acquittee must be held within ten days of the finding of not guilty by reason of insanity. The statute does not require that a forensic evaluation be completed on this issue. However, the court does, on occasion, order such an evaluation from the Forensic Center.

Nonsecured Status (“Second Opinion”) Evaluation Services

When persons committed under sections [2945.39\(A\)\(2\)](#) (IST-U-CJ) and [2945.40](#) (NGRI) are in an ODMH Regional Psychiatric Hospital (RPH), the committing court must approve an increase in some levels of movement (i.e., Level 3—On-Grounds Unsupervised, Level 4—Off-Grounds Supervised, and Level 5—Nonsecured Status; See [Appendix E](#) Movement Policy, MF-04).

When the designee of the department of mental health recommends discharge, termination of the original commitment, or granting the first nonsecured level of movement, a “Second Opinion” evaluation is conducted by the local Community Forensic Psychiatry Center (R.C. [2945.401\(D\)](#)). Nonsecured status is defined as any unsupervised off-grounds movement, a trial visit from the RPH, or conditional release.

In accordance with the ODMH policy, when it has been determined that a request for the first nonsecured status movement is appropriate, the RPH shall send written notification of the recommendation to both the trial court and the local Forensic Center. (The “local” Forensic Center refers to the center that serves the county in which the criminal charges were filed). Included in the notification is the request for a Nonsecured Status evaluation from the Forensic Center. A separate entry from the court is not required. (An example notification form is provided in [Appendix F](#)).

The Forensic Center has thirty days from receipt of the written notice to complete the evaluation. The examiner will interview the patient, review the clinical record, the initial and updated risk assessments, and the conditional release plan, if the request is for conditional release. The evaluation is to be conducted at an ODMH RPH. The Nonsecured Status evaluation report is sent by the Forensic Center to the court and the department’s designee. The court shall provide a copy of the department’s designee’s written request for movement and the center’s written report to the prosecutor and to the counsel for the patient.

The Nonsecured Status report shall indicate agreement or disagreement with the recommendation of the department’s designee. When there is disagreement, the court and the department’s designee shall be informed of the reasons. The department’s designee shall review the Nonsecured Status report, and if the report supports the recommendation of the department’s designee, the court’s approval will be requested. In cases where the Nonsecured Status evaluation is not supportive of the recommendation of the department’s designee, the department’s designee may withdraw, proceed with, or modify and proceed with the request to the court. The court shall make the final decision regarding the request for an increase in movement level.

Additional Evaluations

The evaluation types listed below are not funded by ODMH, but some Forensic Centers perform them under separate contracts with their courts.

Mitigation of Sentence Evaluation Services

Following a plea of guilty or a conviction, the judge may order the probation department to prepare a presentence investigation on the offender. Either the probation department (pursuant to

R.C. [2951.03](#)) or the judge (pursuant to R.C. [2947.06](#)) may request an evaluation of the person's mental condition by a psychiatrist or psychologist as part of the presentence investigation.

An offender cannot be admitted to an ODMH facility solely for the purpose of a mitigation of sentence or presentence evaluation. The court may order a private psychiatrist, psychologist, or a Community Forensic Psychiatry Center to perform the evaluation. If the offender had been released on bail or recognizance, the evaluation should be performed on an outpatient basis. If the offender has not been released, the evaluation should be conducted at the place of detention.

Competence to Stand Trial Evaluation—Juveniles

On September 30, 2011, legislation became effective regarding the evaluation of juveniles' competence to stand trial in juvenile court. Some Community Forensic Psychiatry Centers perform these evaluations. The legislation is included in sections [2152.51](#) to [2152.59](#) of the Revised Code. These laws are not reviewed in this manual because ODMH hospitals are not involved in the treatment of juveniles who have been found to be incompetent to stand trial (with the rare exception of older juveniles who have been bound over to adult court).

Other Evaluations

The Community Forensic Psychiatry Centers provide a number of other evaluations for the courts. Each Forensic Center has made arrangements with their local courts to provide certain kinds of evaluations and these arrangements vary by center. Some of these evaluations include the following: Intervention in Lieu of Conviction (R.C. [2951.041](#)); Juvenile Bindover (Ohio Rules of Juvenile Procedure [Rule 30](#)); Post Sentence Evaluation, Probation or Parole (R.C. [2967.22](#)); Domestic Violence (R.C. [2919.271](#)) and Competence to be a Witness (R.C. [2317.01](#)).

OHIO DEPARTMENT OF MENTAL HEALTH FORENSIC INPATIENT SERVICES

The Ohio Department of Mental Health (ODMH) staff work in collaboration with state and local judicial systems to ensure that people with a mental illness involved in the criminal justice system receive appropriate evaluation and treatment services. The following overview provides more detailed information about the services and procedures provided by ODMH to persons with a forensic status on an inpatient basis.

Inpatient Evaluation Services

Although the vast majority of Competency to Stand Trial (CST) and Sanity (NGRI) Evaluations are conducted on an outpatient basis by the Community Forensic Psychiatry Center examiners, some individuals require inpatient evaluation. This usually occurs when a Forensic Center examiner is unable to conduct an evaluation due to the defendant's lack of cooperation or availability. However, a person may be court ordered for an inpatient competency evaluation without having been referred to a Forensic Center. A Court of Common Pleas may order the person to be admitted to an ODMH Regional Psychiatric Hospital (RPH) for up to 20 days³ in order to be evaluated (R.C. [2945.371\[C\]](#) and [\[D\]](#)). However, when the offense charged is a misdemeanor, the Municipal or County Court may commit the defendant to an RPH for a competency and/or sanity evaluation *only* when this is recommended by a Forensic Center examiner (R.C. [2945.37\[H\]](#) and [2945.371\[D\]](#)). A court-ordered inpatient evaluation should be conducted by an examiner employed by the Regional Psychiatric Hospital to which the defendant was admitted unless otherwise ordered by the court.

When the RPH Legal Assurance Administrator (LAA) receives a court order for an evaluation of a person charged with a misdemeanor, the LAA will inquire whether the Forensic Center examiner recommended an inpatient evaluation and the reason(s) for the recommendation. If the Forensic Center examiner did not make this recommendation, the LAA will determine the reason(s) that the court ordered an inpatient evaluation and inform the court that a recommendation from a Forensic Center examiner is required by statute.

The Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or Community Mental Health (CMH) Board for the county of the committing court is financially responsible for the payment of inpatient evaluation services, so the LAA must notify the Board about the admission.

All of ODMH RPHs provide competency and sanity evaluations. See [Appendix A](#) for a list of the RPHs and [Appendix B](#) for their catchment areas.

Competence to Stand Trial Evaluation – Section 2945.371(G)(3)

When the issue of a defendant's competence to stand trial is raised, the judge may order an inpatient evaluation of the person's competence to stand trial.

Appropriate Admission: A person should be admitted to an ODMH RPH for a competency to stand trial evaluation only in situations in which the Community Forensic Psychiatry Center

³ In the Revised Code, the word "days" means calendar days unless the law specifically uses the words "court days." However, if the final day of a period falls on a weekend or holiday, then the final day is the next business day.

examiner is unable to complete the evaluation in the community. Defendants who have been charged with a misdemeanor and who have not been released on bail or recognizance should not be admitted for an inpatient evaluation unless an examiner from a certified Community Forensic Psychiatry Center makes this recommendation (R.C. [2945.371\(D\)](#)). For defendants who have been charged with a felony and who have not been released on bail or recognizance, courts should use the services of their Forensic Center, but may order an inpatient evaluation in rare circumstances. If a defendant has been released on bail or recognizance, the court may order an inpatient evaluation without an examiner's recommendation if the defendant refuses to voluntarily submit to an outpatient examination. The court may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver the defendant to a center, program or facility operated or certified by ODMH or the Ohio Department of Developmental Disabilities ([DODD](#)). Defendants admitted for an inpatient evaluation may not change their legal status to a voluntary admission status.

Court Order: The court order (journal entry) should contain the following information: the date filed; the defendant's name; the Criminal Court case number; the names of the judge, prosecutor, and defense attorney; the offense(s) charged; an indication of whether the defendant has been released on bail or recognizance; the name of the examiner recommending inpatient evaluation for competency; a statement to the effect that the court is ordering an inpatient evaluation for competency pursuant to section [2945.371\(G\)\(3\)](#) of the Revised Code; and the name of the person to notify when the evaluation is completed. If these items are not included in the court order, the LAA may contact the court administrator to request the necessary information.

Reasonable Time Limit: When a defendant is admitted to an ODMH RPH for an inpatient evaluation, the defendant may be retained for a reasonable period of time not to exceed twenty days. If a delay between the court order and the defendant's admission to the RPH does not allow adequate time to complete the evaluation, the LAA should seek an amended entry from the court. In extraordinary situations, if the examiner requires additional time to complete the evaluation, an extension should be requested from the court. If either of these situations occurs, the LAA shall notify the ADAMHS or CMH Board for the County of the Committing Court.

Upon the completion of the competency evaluation and within the designated time, the RPH Chief Clinical Officer (CCO) or designee, shall contact the person named in the court order to convey the patient.

Reporting Requirements: The examiner must submit a written report to the court within thirty days of the filing date of the journal entry ordering the evaluation. The court will distribute the report to the prosecutor and defense counsel. If the court orders an evaluation of both the defendant's competence to stand trial and mental condition at the time of the offense (sanity), the examiner must file two separate reports addressing competency and sanity. If the defendant is assessed as not meeting the criteria for competency to stand trial, the sanity report should not be prepared until the defendant is restored to competency.

Report Contents: The examiner's report shall contain a description of the person's current mental status and a reasonably detailed description of the basis for the clinical findings. (See [Appendix G](#): Examination and Report Formats for Competence to Stand Trial and Not Guilty by Reason of Insanity evaluations.)

The report shall include all of the following:

1. The examiner's findings;
2. The facts in reasonable detail on which the findings are based;
3. Whether the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's own defense;
4. If the examiner's opinion is that the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, whether the defendant presently is mentally ill or mentally retarded and, if the examiner's opinion is that the defendant is presently mentally retarded, whether the defendant appears to be a mentally retarded person subject to institutionalization by court order;
5. If the examiner's opinion is that the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, the examiner's opinion as to the likelihood of the defendant becoming capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense within one year⁴ if the defendant is provided with a course of treatment.
6. If the examiner's opinion is that the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense and that the defendant presently is mentally ill or mentally retarded and likely to be restored within a year, the examiner's recommendation as to the least restrictive treatment alternative, consistent with the defendant's treatment needs for restoration to competency and with the safety of the community.

No conclusory statement is required about the defendant's competence to stand trial.

No statement that a defendant makes in a competency evaluation or hearing under sections [2945.371](#) (A) through (H) of the Revised Code may be used against the defendant to prove guilt. However, in a criminal action or proceeding, the prosecutor or defense counsel may call as a witness any person who evaluated the defendant or prepared a report concerning a defendant's competence. If the examiner's report indicates that the defendant does not meet the competency criteria and appears to be a mentally retarded person subject to institutionalization by court order, the court will order a separate mental retardation evaluation conducted by a psychologist designated by the Director of the Department of Developmental Disabilities.

Rights and Movement: A patient committed for evaluation under Section 2945.371 is not eligible for voluntary admission or movement. (See Appendix D, Movement Policy, [MF-04](#)).

Time Served: Pursuant to section [2945.38\(I\)](#) of the Revised Code, if a defendant is convicted of a crime and sentenced to a jail or workhouse, the defendant's sentence shall be reduced by the total number of days the defendant is confined for evaluation to determine the defendant's competence

⁴ A defendant may be required to undergo treatment for the purpose of restoration of competency to stand trial for a period of thirty days to one year, depending upon the severity of the offense, pursuant to section [2945.38\(C\)](#) of the Revised Code.

to stand trial or treatment under that section and sections [2945.37](#) and [2945.371](#) of the Revised Code or by the total number of days the defendant is confined for evaluation to determine the defendant's mental condition at the time of the offense charged.

(NOTE: For the proceedings following a competency evaluation, please refer to the section of the manual titled [Procedures Following an Evaluation of Competence to Stand Trial](#)).

Sanity Evaluation – Section 2945.371 (G)(4)

When a defendant enters a plea of not guilty by reason of insanity, the judge may order an inpatient evaluation of the person's mental condition at the time of the offense charged.

Appropriate Admission: A person should be admitted to an ODMH RPH for a sanity evaluation only in situations in which the Community Forensic Psychiatry Center examiner is unable to complete the evaluation in the community. Defendants who have been charged with a misdemeanor and who have not been released on bail or recognizance should not be admitted for an inpatient evaluation unless an examiner from a certified Forensic Center makes this recommendation (R.C. [2945.371\(D\)](#)). For defendants who have been charged with a felony and who have not been released on bail or recognizance, courts should use the services of their Forensic Center, but may order an inpatient evaluation in rare circumstances. If a defendant has been released on bail or recognizance, the court may order an inpatient evaluation without an examiner's recommendation if the defendant refuses to voluntarily submit to an outpatient examination. The court may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver the defendant to a center, program or facility operated or certified by ODMH or the [Ohio Department of Developmental Disabilities](#) (DODD). Defendants admitted for inpatient evaluation may not change their legal status to a voluntary admission status.

Court Order: The court order (journal entry) should contain the following information: the date filed; the defendant's name; the Criminal Court case number; the names of the judge, prosecutor, and defense attorney; the offense(s) charged; an indication whether the defendant has been released on bail or recognizance; the name of the examiner recommending inpatient evaluation for mental condition at the time of the offense; a statement to the effect that the court is ordering an inpatient evaluation pursuant to section [2945.371\(G\)\(4\)](#) of the Revised Code; and, the name of the person to notify when the evaluation is completed. If these items are not included in the court order, the LAA should contact the court administrator to request the necessary information.

Reasonable Time Limit: When a defendant is admitted to an ODMH RPH for an inpatient evaluation, the defendant may be retained for a reasonable period of time not to exceed twenty days. If a delay between the date of the court order and the defendant's admission to the RPH does not allow adequate time to complete the evaluation, the LAA should seek an amended entry from the court. In extraordinary situations, if the examiner requires additional time to complete the evaluation, an extension should be requested from the court. If either of these situations occurs, the LAA shall notify the ADAMHS or CMH Board for the County of the Committing Court.

Upon the completion of the evaluation and within the designated time, the RPH Chief Clinical Officer (CCO) or designee shall contact the person named in the court order to convey the patient.

Reporting Requirements: The examiner must submit a written report to the court within thirty days of the filing date on the court order for the evaluation. The court will distribute the report to the prosecutor and defense counsel. If the court orders an evaluation of both the defendant's competence to stand trial and mental condition at the time of the offense (sanity), the examiner must file two separate reports addressing competency and sanity. If the defendant is assessed as not meeting the criteria for competency to stand trial, the sanity report should not be prepared until the defendant is restored to competency. If the hospital receives a court order to perform a sanity evaluation on a defendant who is assessed as not meeting the criteria for competency to stand trial or has already been found by the court to be not competent to stand trial, the RPH CCO should contact central office. The legal services office, forensic services office and medical director's office will provide further guidance.

In conducting an evaluation of a defendant's mental condition at the time of the offense charged, the examiner shall consider all relevant evidence. If the offense charged involves the use of force against another person, the relevant evidence to be considered includes, but is not limited to, any evidence that the defendant suffered, at the time of the commission of the offense, from the "battered woman syndrome" (R.C. [2945.392](#)).

Report Contents: The examiner's report should contain:

1. The examiner's findings;
2. The facts in reasonable detail on which the findings are based;
3. The examiner's findings as to whether the defendant, at the time of the offense charged, did not know, as a result of severe mental disease or defect, the wrongfulness of the defendant's acts charged.

(See [Appendix G](#): Examination and Report Format for Competence to Stand Trial and Not Guilty by Reason of Insanity Evaluations.)

Rights and Movement: A patient committed for evaluation under Section 2945.371 is not eligible for voluntary admission or movement. (See [Appendix D](#), Movement Policy, MF-04).

Time Served: Pursuant to section [2945.38\(I\)](#) of the Revised Code, if a defendant is convicted of a crime and sentenced to a jail or workhouse, the defendant's sentence shall be reduced by the total number of days the defendant is confined for evaluation to determine the defendant's competence to stand trial or treatment under that section and sections [2945.37](#) and [2945.371](#) of the Revised Code or by the total number of days the defendant is confined for evaluation to determine the defendant's mental condition at the time of the offense charged.

(NOTE: For the proceedings following a Sanity Evaluation, please refer to the section of the manual titled [Procedures Following a Finding of Not Guilty by Reason of Insanity](#).)

Procedures Following an Evaluation of Competence to Stand Trial

If the issue of a defendant's competence to stand trial is raised and the court finds that the defendant is competent to stand trial, the defendant shall be proceeded against as provided by law. If the court finds the defendant is competent to stand trial and the defendant is receiving psychotropic drugs or other medication, the court may authorize the continued administration of medication to maintain competence if this is in accordance with the attending physician's orders.

If the court finds that the defendant is incompetent to stand trial and that, even if provided with a course of treatment, there is not a substantial probability that the defendant will become competent to stand trial within one year, the court shall order the discharge of the defendant, unless upon motion of the prosecutor or on its own motion, the court either seeks to retain jurisdiction over the defendant pursuant to section [2945.39\(A\)\(2\)](#) of the Revised Code, or files an affidavit in the probate court for the civil commitment of the defendant pursuant to Chapter [5122](#) or [5123](#). If an affidavit is filed in the probate court, the trial court shall send to the probate court copies of all written reports of the defendant's mental condition that were prepared pursuant to section [2945.371](#) of the Revised Code.

The trial court may issue a temporary order of detention pursuant to sections [5122.11](#), [5123.74](#), or [5123.77](#) of the Revised Code to remain in effect until the probable cause or initial hearing in the probate court.

If after taking into consideration all relevant reports, information, and other evidence, the court finds a defendant incompetent to stand trial and that there is a substantial probability that the defendant will become competent to stand trial within one year if provided with a course of treatment, the court shall order the defendant to undergo treatment.

Incompetent to Stand Trial—Restoration Treatment—Section 2945.38 (B)

When a defendant has been found incompetent to stand trial, the Common Pleas or Municipal Court may order that the defendant undergo treatment.

If the defendant has been charged with a felony offense and if, after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial, but the court is unable at that time to determine whether there is a substantial probability that the defendant will become competent to stand trial within one year⁵ if the defendant is provided with a course of treatment, the court shall order continuing evaluation and treatment of the defendant for a period not to exceed four months to determine whether 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 (R.C. [2945.38\[B\]\[1\]\[a\]](#)).

If the defendant is determined to require mental health treatment or continuing evaluation and treatment, the defendant either shall be committed to the department of mental health for treatment or continuing evaluation and treatment at a hospital, facility, or agency, as determined

⁵ A defendant may be required to undergo treatment for the purpose of restoration of competency to stand trial for a period of six months to one year, depending upon the severity of the *felony* offense, pursuant to section [2945.38\(C\)](#) of the Revised Code. See [Appendix F](#).

to be clinically appropriate by the Department of Mental Health or shall be committed to a facility certified by ODMH as being qualified to treat mental illness, to a public or community mental health facility, or to a psychiatrist or another mental health professional for treatment or continuing evaluation and treatment. If the defendant is determined to require treatment or continuing evaluation and treatment for mental retardation, the defendant shall receive treatment or continuing evaluation and treatment at an institution or facility operated by [DODD](#), at a facility certified by DODD as being qualified to treat mental retardation, at a public or private mental retardation facility, or by a psychiatrist or another mental retardation professional.

Admission to an ODMH Facility: In determining the place of commitment, the court shall consider the extent to which the person is a danger to self and to others, the need for security, and the type of crime involved and shall order the least restrictive alternative available that is consistent with public safety and treatment goals. In weighing these factors, the court shall give preference to protecting public safety.

When an individual is admitted to an ODMH RPH for restoration treatment or continuing evaluation and treatment, the RPH Legal Assurance Administrator (LAA) shall notify the ADAMHS or CMH Board for the County of the Committing Court (county where the criminal charges were filed) **and** the County of Legal Residence (home county) if this is a different county.

Admission Documents: The following documents should accompany the defendant when he or she is committed to an ODMH RPH in this status:

1. A court order (journal entry) which states that the commitment is pursuant to section [2945.38\(B\)](#) of the Revised Code; the commitment date; the criminal court case number; the names of the judge, prosecutor, and defense attorney; and a clear statement of the maximum length of time for which the person has been committed. The order may restrict the defendant's movement, as the court considers necessary.
2. A copy of the indictment stating the offense(s) with which the defendant has been charged.
3. Copies of relevant police reports and other background information that pertain to the defendant and are available to the prosecutor, unless the prosecutor determines that the release of any of the information in the police reports or any of the other background information to unauthorized persons would interfere with the effective prosecution of any person or would create a substantial risk of harm to any person.
4. Copies of any psychiatric and psychological evaluations that were prepared for the court in order to determine the defendant's competence to stand trial.

If any of the above documents are not received by the RPH, the LAA should contact the prosecutor.

Placement: The placement of a defendant committed as incompetent to stand trial is guided by the Department of Mental Health's service areas established for each of its facilities unless it is determined by the court that a maximum security setting is required or unless the department determines that placement in another hospital, facility or agency is clinically appropriate. Before moving the defendant from a hospital to another facility or agency, the approval of the trial court

must be obtained. All ODMH RPHs provide inpatient restoration treatment at all six hospital sites: Appalachian Behavioral Healthcare in Athens; Northcoast Behavioral Healthcare in Northfield; Northwest Ohio Psychiatric Hospital in Toledo; Twin Valley Behavioral Healthcare in Columbus; Summit Behavioral Healthcare in Cincinnati; and Heartland Behavioral Healthcare in Massillon. See the Catchment Area Maps in [Appendix B](#) for the counties served by each RPH.

Amended Placement: Refer to the [Transfer Policy \(I-02\)](#) in Appendix H.

Medication: When a defendant is committed pursuant to section [2945.38\(B\)](#) of the Revised Code for restoration treatment or continuing evaluation and treatment to an ODMH RPH, the Chief Clinical Officer (CCO) of the RPH may determine that medication is necessary to restore the defendant's competence to stand trial. If the defendant lacks the capacity to give informed consent or refuses medication, the CCO may petition the court for authorization for the involuntary administration of medication. If the defendant is charged with a misdemeanor, the petition is filed in a Municipal Court or a County Court and the court shall hold a hearing within five days of the filing. For defendants with felony charges, the petition is filed with the Common Pleas Court and the court shall hold a hearing within ten days of the petition being filed.

Following the hearing, the court may authorize the involuntary administration of medication or may dismiss the petition.

(For additional information, please see the Guidelines for ODMH RPH Informed Consent Policy (MD-11) in [Appendix I](#)).

Reporting Requirements: The person who supervises the treatment of a defendant ordered to undergo restoration treatment service must submit a written report prepared by a psychiatrist or licensed clinical psychologist to the court at the following times:

1. Whenever the person believes the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense;
2. For a felony offense, fourteen days before the expiration of the maximum time for treatment as specified in section [2945.38\(C\)](#) of the Revised Code or fourteen days before the expiration of the maximum time for continuing evaluation and treatment as specified in (B)(1)(a) of that section, and for a misdemeanor offense, ten days before the expiration of the maximum time for treatment as specified in section [2945.38\(C\)](#);
3. At a minimum, after each six months of treatment; or
4. Whenever the person who supervises the treatment or continuing evaluation and treatment of a defendant committed under section [2945.38\(B\)\(1\)\(a\)](#) of the Revised Code believes that there is not a substantial probability that the defendant will meet Ohio's competence criteria even if the defendant continues to receive treatment.

Report Guidelines: Each report must contain a description of the defendant's history, current mental status, the examiner's findings, the facts in reasonable detail on which the findings are based, and the examiner's opinion as to the defendant's capability of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's

defense. If, in the examiner's opinion, the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense and there is a substantial probability that the defendant will meet Ohio's competence criteria if provided with a course of treatment and in the examiner's opinion the defendant remains mentally ill or mentally retarded, and if the maximum time for treatment as specified in section [2945.38\(C\)](#) of the Revised Code has not expired, the report shall contain the examiner's recommendation as to the least restrictive treatment alternative that is consistent with the defendant's treatment needs for restoration to competency and with the safety of the community.

Using the criteria outlined in the report guidelines, (See [Appendix G](#)) an internal review should occur prior to the report being sent to the court. The review should be conducted by the CCO or designee. The court will provide copies of the report to the prosecutor and defense counsel.

Movement: A defendant committed to an RPH for competency restoration may not be permitted to apply for voluntary admission and is limited to Level 1 and Level 2 movement. The court may grant a defendant Supervised Off-Grounds movement (Level 4) to obtain medical treatment or specialized habilitation treatment services if the person who supervises the treatment informs the court that the treatment cannot be provided at the RPH. In emergencies, the CCO or designee of the RPH may grant a defendant movement to a medical facility with appropriate supervision to ensure the safety of the defendant, staff, and community. The CCO or designee shall notify the court within twenty-four hours if this occurs. See Movement Policy (MF-04) in [Appendix D](#).

Expiration of Commitment: The maximum length of time for which the defendant may be committed under an order from the Criminal Court should appear in the court order. Pursuant to section [2945.38\(C\)](#) of the Revised Code no defendant shall be required to undergo restoration treatment, including any continuing evaluation and treatment, longer than whichever of the following periods is applicable:

1. One year, if the most serious offense with which the defendant is charged is one of the following offenses:
 - a. Aggravated murder, murder, or an offense of violence for which the defendant could receive a sentence of death or life imprisonment;
 - b. An offense of violence that is a felony of the first or second degree;
 - c. A conspiracy to commit, an attempt to commit, or complicity in the commission of an offense described in (a) or (b) above if the conspiracy, attempt, or complicity is a felony of the first or second degree.
2. Six months if the most serious offense with which the defendant is charged is a felony other than a felony described above.
3. Sixty days, if the most serious offense with which the defendant is charged is a misdemeanor of the first or second degree.
4. Thirty days, if the most serious offense with which the defendant is charged is a misdemeanor of the third or fourth degree, a minor misdemeanor, or an unclassified misdemeanor.

Pursuant to section [2945.38\(H\)](#) of the Revised Code, within ten (10) days after the treating physician or examiner advises that there is not a substantial probability that the defendant will be restored to competency even if provided with a course of treatment, or within ten (10) days after the expiration of the maximum time for treatment as specified in section [2945.38\(C\)](#), or within ten (10) days after the expiration of the maximum time for continuing evaluation and treatment, or within thirty (30) days after a defendant's request for a hearing that is made after six months of treatment, or within thirty (30) days after being advised by the treating physician that the defendant is competent to stand trial, whichever is earliest, the court shall conduct another hearing to determine if the defendant is competent to stand trial and shall do whichever of the following is applicable:

1. If the court finds that the defendant is competent to stand trial, the defendant shall be proceeded against as provided by law.
2. If the court finds that the defendant is incompetent to stand trial, but there is a substantial probability that the defendant will become competent to stand trial if the defendant is provided with a course of treatment and the maximum time for treatment as specified in section [2945.38\(C\)](#) of the Revised Code has not expired, the court, after consideration of the examiner's recommendation, shall order that treatment be continued until the expiration of the maximum time for treatment. The court may change the place of commitment at which the treatment is to be continued, and shall specify this in the court order.
3. If the court finds that the defendant is incompetent to stand trial, if the defendant is charged with an offense listed in section [2945.38\(C\)\(1\)](#) of the Revised Code and the court finds that there is not a substantial probability that the defendant will become competent to stand trial even if the defendant is provided with a course of treatment, or if the maximum time for treatment relative to that offense as specified in Section 2945.38(C) has expired, further proceedings shall be as provided in sections [2945.39](#), [2945.401](#) and [2945.402](#). of the Revised Code.
4. If the court finds that the defendant is incompetent to stand trial, if the most serious offense with which the defendant is charged is a misdemeanor or a felony other than those listed in section [2945.38\(C\)\(1\)](#) of the Revised Code, and if the court finds that there is not a substantial probability that the defendant will become competent to stand trial even if provided with a course of treatment, or if the maximum time for treatment has expired, the court shall dismiss the indictment, information, or complaint against the defendant. A dismissal under this division is not a bar to further prosecution based on the same conduct.

The court shall discharge the defendant unless the court or prosecutor files an affidavit in probate court for civil commitment pursuant to chapter [5122](#) or [5123](#) of the Revised Code.

Incompetent to Stand Trial—Unrestorable—Probate Court Jurisdiction
Section 2945.38 (H)(4)

If an affidavit for civil commitment has been filed, the trial court may detain the defendant for ten days pending civil commitment. If the defendant is committed by the probate court to an ODMH Regional Psychiatric Hospital (RPH), the Chief Clinical Officer (CCO) shall ensure that

the required notices are sent to the prosecutor as outlined in section [2945.38\(H\)\(4\)\(a\)\(i-iii\)](#) of the Revised Code. See the *Reporting Requirements* below for additional information.

Admission Criteria: Persons who are found incompetent to stand trial and unrestorable, and who require inpatient mental health services, can be probated to an ODMH hospital. When this occurs, all future court proceedings will be civil proceedings in the probate court as provided for in chapter [5122](#) of the Revised Code. These patients are still considered to be on a forensic status, and the forensic and risk management policies ([MF-03](#), [MF-04](#)) and procedures apply to them.

The RPH Legal Assurance Administrator (LAA) shall notify the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or the Community Mental Health (CMH) Board of the County of Legal Residence (home county) when a resident of their county is hospitalized in an IST-U status. The ADAMHS/CMH Board is financially responsible for patients hospitalized under this legal status.

Court Documents: The probate court will send to the RPH a copy of the order for commitment, a copy of the court order (journal entry) stating that the person was found incompetent to stand trial and unlikely to be restored, and the examiner's report. If any of these items are missing the LAA should contact the prosecutor.

Criminal Charge: When the trial court finds a defendant incompetent to stand trial and unlikely to be restored, the criminal charges are to be dismissed pursuant to section [2945.38\(H\)\(4\)](#) of the Revised Code.

Reporting Requirements: The RPH CCO/designee, the director of the program, or the person to whom the defendant is committed shall do all of the following:

1. Notify the prosecutor, in writing, of the discharge of the defendant at least ten days prior to the discharge unless the discharge is by the probate court, and state in the notice the date on which the defendant will be discharged;
2. Notify the prosecutor, in writing, when the defendant is absent without leave or is granted unsupervised, off-grounds movement, promptly after the discovery of the absence without leave or prior to the granting of unsupervised, off grounds movement, whichever is applicable;
3. Notify the prosecutor, in writing, of the change of the defendant's commitment or admission to voluntary status, send the notice promptly upon learning of the change to voluntary status, and state in the notice the date on which the defendant was committed or admitted on a voluntary status.

Upon receiving notice that the defendant will be granted unsupervised, off-grounds movement, the prosecutor will either reindict the defendant or promptly notify the trial court that the prosecutor does not intend to prosecute the charges against the defendant.

Rights and Movement: A person committed by the probate court, after being found incompetent to stand trial and unlikely to be restored, shall be permitted to apply for a voluntary admission under the following conditions:

1. The treating physician must sign a statement for the medical record that the patient has the capacity to comprehend the implications of a voluntary admission; or
2. The patient's adjudicated legal guardian applies for the patient's voluntary admission and the implications of a voluntary admission have been explained to the legal guardian.

Persons who are committed pursuant to section [2945.38\(H\)\(4\)](#) of the Revised Code are permitted Level 1 through Level 5 movement, according to the Movement Policy (MF-04) in [Appendix D](#).

Discharge: A person who is committed as incompetent to stand trial and unlikely to be restored may be discharged when the person is found to no longer require inpatient services, and a lesser restrictive environment is a more appropriate placement. The prosecutor shall be notified in writing, usually by certified mail, of the planned discharge. This notification is required to occur at least ten days prior to the patient's discharge, unless the discharge is by the probate court.

The ADAMHS/CMH Board's designated community treatment representative(s) should work with the RPH staff in gathering information and developing a plan for the patient's discharge. This should include attendance and participation in the RPH treatment team meetings, and individual meetings with the patient to prepare for discharge. The importance of community and RPH service providers working together to develop a comprehensive and appropriate discharge plan is key to a successful transition for the individual involved.

Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction
Section 2945.39(A)(2)

Court Process: In accordance with section [2945.39\(A\)\(2\)](#) of the Revised Code, if a defendant charged with an offense described in section [2945.38\(C\)\(1\)](#) is found incompetent to stand trial, and either the maximum time for treatment has expired, or the court has found that the defendant is unlikely to become competent to stand trial even if the defendant is provided with a course of treatment, and upon the motion of the court or the prosecutor, the trial court can retain jurisdiction over the defendant if, at a hearing, the court finds both of the following by clear and convincing evidence:

1. The defendant committed the offense with which the defendant is charged, and
2. The defendant is a mentally ill person subject to hospitalization by court order or a mentally retarded individual subject to institutionalization by court order.

In making its determination under section [2945.39\(A\)\(2\)](#) of the Revised Code as to whether to retain jurisdiction over the defendant, the court may consider all relevant evidence, including, but not limited to, any relevant psychiatric, psychological, or medical testimony or reports, the acts constituting the offense charged, and the defendant's history that is relevant to the defendant's ability to conform to the law.

A defendant who is committed under section [2945.39\(A\)\(2\)](#) of the Revised Code as Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction (IST-U-CJ), shall remain under the trial court's jurisdiction until the final termination of the commitment as described in section

[2945.401\(J\)\(1\)](#). At the time that the jurisdiction is terminated due to the expiration of the maximum prison term or term of imprisonment described in section [2945.401\(J\)\(1\)\(b\)](#), the court or prosecutor may file an affidavit for civil commitment with the probate court if it is believed that the individual meets the criteria for hospitalization.

A defendant with an IST-U-CJ status, if determined to require mental health treatment, shall be committed either to the Department of Mental Health for treatment at a hospital, facility, or agency as determined clinically appropriate by ODMH, or to another medical or psychiatric facility as appropriate. Before moving the defendant from a hospital to another facility or agency, the approval of the trial court must be obtained. If determined to require treatment for mental retardation the court shall commit the defendant to a facility operated by the Department of Developmental Disabilities ([DODD](#)), or another facility, as appropriate. The court shall be notified at any time during this commitment if the defendant is assessed as competent to stand trial (See R.C. [2945.401\[C\]](#) and [2945.401\[J\]\[2\]\[a\]](#)).

The court may commit the defendant to an ADAMHS/CMH Board or a community mental health agency under a conditional release commitment pursuant to section [2945.402\(A\)](#) of the Revised Code. The defendant remains under the trial court's jurisdiction, receives the necessary community mental health services, and is monitored in the community by the Forensic Monitor for the ADAMHS/CMH Board of the county of the committing court. (See Community Forensic Monitoring Program Section for the [Guidelines for Conditional Release Directly from the Court to the Community](#)).

If the court does *not* find, by clear and convincing evidence, that the defendant committed the offense charged and that the defendant is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the court shall dismiss the indictment against the defendant. Upon dismissal, the court shall discharge the defendant unless the court or prosecutor files an affidavit in probate court for civil commitment. A dismissal of the charges is not a bar to further criminal proceedings based on the same conduct.

Admission Criteria: If the defendant is found by clear and convincing evidence to have committed the act charged and is a mentally ill person subject to hospitalization, the court may commit the defendant to ODMH.

A person who is committed pursuant to section [2945.39](#) of the Revised Code shall not be voluntarily admitted to a hospital or institution pursuant to sections [5122.02](#), [5122.15](#), [5123.69](#) or [5123.76](#).

Court Documents: The RPH or facility where the defendant is committed will receive a copy of the court order from the trial court stating that the person is Incompetent to Stand Trial—Unrestorable under Criminal Court Jurisdiction (IST-U-CJ). The court should also send a copy of the indictment or complaint and a copy of each examiner's report and any other information that the court deems relevant. The prosecutor will send to the place of commitment all reports of the defendant's current mental condition and other relevant information including but not limited to, a transcript of the hearing held pursuant to section [2945.39\(D\)\(2\)](#), copies of relevant police reports, copies of any prior arrest and conviction records that pertain to the defendant and that the prosecutor possesses. The prosecutor will send the reports of the defendant's current mental condition in every case of commitment, and, unless the prosecutor determines that the release of

any of the other relevant information to unauthorized persons would interfere with the effective prosecution of any person or would create a substantial risk of harm to any person, the prosecutor will also send the other relevant information.

The RPH LAA will work with the court and prosecutor to obtain this information in order to assist staff in preparing evaluations, social histories, risk assessments and treatment plans.

Community Notification Requirements: When a defendant is committed by the court to ODMH under section [2945.39\(A\)\(2\)](#) of the Revised Code, the LAA of the RPH where the person is placed shall notify the ADAMHS or CMH Board of the County of the Committing Court (the county where the charges were filed) about the admission. The LAA will provide the Board with a copy of all reports of the person's current mental condition, a copy of all relevant information provided by the prosecutor, including, if provided, a copy of the transcript of the hearing held pursuant to section [2945.39\(A\)\(2\)](#), the relevant police reports, and the prior arrest and conviction records that pertain to the defendant and that the prosecutor possesses. If the individual is directly committed by the court to a community agency, the agency will send the above documents to the ADAMHS or CMH Board for the County of the Committing Court.

Reporting Requirements: The RPH LAA will ensure that a written report is submitted to the court at the end of the initial six months of treatment and every two years after the initial report. The report will indicate whether the defendant remains a mentally ill person subject to hospitalization by court order and whether the defendant remains incompetent to stand trial. The court will give copies of the report to the prosecutor and defense counsel. Within thirty days after receipt of a report from the RPH, the trial court will hold a hearing on the continued commitment of the defendant, or regarding any changes in the conditions of the commitment of the defendant. If the defendant requests a change in the conditions of commitment, the trial court will conduct a hearing on that request if six months or more have elapsed since the most recent hearing was conducted under section [2945.401\(C\)](#).

Movement - Level 2

A defendant who is in an IST-U-CJ status and committed to ODMH and placed at an RPH remains under the trial court's jurisdiction. Patients charged with aggravated murder, murder, or felony 1 or felony 2 offenses must have approval of the RPH treatment team and the RPH Forensic Review Team (FRT) prior to granting Level 2 movement. Patients charged with lesser offenses are allowed Level 2 (Off Residential Unit, Supervised Movement) after review and approval by only the RPH treatment team.

Movement - Levels 3 and 4

Prior to a request for an additional movement level, the treatment team will review all risk assessments that have been conducted on the individual, and will conduct a current risk assessment update. After an evaluation of the risks to public safety along with a consideration of the welfare of the patient, their recommendation for movement will be forwarded to the RPH Forensic Review Team (FRT). The FRT will review all movements of patients with an IST-U-CJ status prior to Level 3 movement or above. If the FRT is in agreement, the request will be sent to the RPH CCO.

The department's designee/CCO will review the request for movement and the related documents. If the department's designee/ CCO agrees, an application will be filed with the trial court for approval of On-Grounds, Unsupervised Movement (Level 3), or Off-Grounds, Supervised Movement (Level 4). A copy of the application for approval of movement will be sent to the prosecutor. If the prosecutor does not request a hearing within 15 days, the trial court will either approve the request of the department's designee/CCO or may hold a hearing on its own accord within 30 days. If the prosecutor requests a hearing, the court must hold a hearing within 30 days of the request, and the court must notify the prosecutor 15 days prior to the hearing date. The court will make a decision regarding the request for movement, and will enter its order accordingly. See the Movement Policy (MF-04) in [Appendix D](#).

At any time after evaluating the risks to public safety and the welfare of the defendant, the department's designee/CCO may recommend a termination of the commitment or a change in the conditions of the commitment (R.C. [2945.401\(D\)\(1\)](#)).

Movement - Nonsecured Status: Level 5 Movement, Off Grounds, Unsupervised; Trial Visit; or Conditional Release

A nonsecured status is defined as any unsupervised, off-grounds movement, trial visit from an RPH or institution, or conditional release, that is granted to a person who has been committed under sections [2945.39](#) (IST-U-CJ) or [2945.40](#) (NGRI). The RPH treatment team and FRT review process for this movement level remain the same as required prior to requesting a Level 3 or 4 movement. When the treatment team and the FRT are in agreement that the individual should be granted the first nonsecured status, the request is sent to the CCO.

The department's designee/CCO will review the related information and if in agreement with the request, will send written notification of this recommendation to the trial court and the local Community Forensic Psychiatry Center. (The "local" Forensic Center refers to the center that serves the county in which the criminal charges were filed). Included in the notification is the request for a Nonsecured Status ("Second Opinion") evaluation of the patient by a Forensic Center examiner and the conditional release plan when the request is for conditional release. The RPH LAA shall coordinate this process and ensure that the appropriate documentation is sent. A separate entry from the court is not required. Some RPHs have developed forms to notify the court of the recommendation of the department's designee/CCO and simultaneously request a Second Opinion evaluation from the Community Forensic Psychiatry Center. (An example notification form is provided in [Appendix F](#)).

The Community Forensic Psychiatry Center will conduct a Nonsecured Status evaluation of the individual at the RPH and within thirty days after receiving the notification will send a written report to the department's designee/CCO and the trial court. The court will provide a copy of the department designee's/CCO's written notice and the Forensic Center's written report to the prosecutor and the counsel for the defendant. Upon the submission of the Nonsecured Status evaluation report to the court and the department's designee/CCO, all of the following apply:

1. If the Forensic Center disagrees with the recommendation of the department's designee/CCO, the Forensic Center shall inform the department's designee/CCO and the trial court of the disagreement and the reasons for the decision. The department's designee/CCO, after consideration of the Forensic Center's decision, shall either withdraw, proceed with, or modify and proceed with the recommendation. If the department's

designee/CCO proceeds with, or modifies and proceeds with, the recommendation, the department's designee/CCO shall proceed in accordance with section [2945.401\(D\)\(1\)\(b\)\(iii\)](#) of the Revised Code. (See Number 3 below).

2. If the Forensic Center agrees with the recommendation of the department's designee/CCO, it shall inform the department's designee/CCO and the court of this decision and the reasons for the decision. The department's designee/CCO shall proceed as indicated below.
3. If the Forensic Center disagrees with the recommendation of the department's designee/CCO, and the department's designee/CCO proceeds with or modifies and proceeds with the recommendation, or if the Forensic Center agrees with the recommendation of the department's designee/CCO, the department's designee/CCO or designee shall work with community mental health agencies, programs, facilities or the ADAMHS/CMH Board for the County of the Committing Court to develop a plan to implement the recommendation. The board-designated community Forensic Monitor and the community mental health service provider should work with the RPH staff to develop this plan. If the recommendation is for conditional release, the conditional release (CR) plan will identify the specific conditions that the individual is required to follow in the community. The CR plan will also include the steps to be taken and the parties responsible to carry out those steps if the defendant violates the conditions of the plan. (See [Appendix J](#) for the Discharge and Conditional Release Plan Guidelines). If the defendant is taking medication, the plan shall include, but not be limited to, a system to monitor the defendant's compliance with the prescribed medication treatment plan. The plan/system shall include a schedule that clearly states when the defendant reports for medication compliance checks. The medication compliance checks will be based on the effective duration of the prescribed medication, taking into account the route by which it is taken, and will be scheduled at intervals sufficiently close together to detect a potential increase in mental illness symptoms that the medication is intended to prevent (R.C. [2945.401\[D\]\[1\]\[b\]\[iii\]](#)).

The department's designee/CCO, after consultation with the ADAMHS or CMH Board, will send the recommendation and written plan to the trial court, the prosecutor, and the defendant's counsel. The trial court will conduct a hearing on the recommendation and plan. In accordance with R.C. Section 2945.401(D)(1)(c) and (d) and (E) to (J), the following applies to these hearings:

1. If the department's designee's/CCO's recommendation is for nonsecured status or termination of the commitment, the prosecutor may obtain an independent expert evaluation of the defendant's mental condition, and the trial court may continue the hearing on the recommendation for a period of not more than 30 days to permit time for the evaluation. The prosecutor may introduce the evaluation report or present other evidence at the hearing in accordance with the rules of evidence.
2. The trial court will schedule the hearing on the department's designee's/CCO's recommendation for nonsecured status or termination of commitment and will give reasonable notice to the prosecutor and the defendant's counsel. Unless continued for independent evaluation at the prosecutor's request or for other good cause, the hearing will be held within 30 days after the trial court's receipt of the recommendation and plan.

The trial court, in making a determination regarding nonsecured status or termination of commitment, will consider all relevant factors including, but not limited to, all of the following:

1. Whether, in the trial court's view, the defendant currently represents a substantial risk of physical harm to the defendant or others;
2. Psychiatric and medical testimony as to the current mental and physical condition of the defendant;
3. Whether the defendant has insight into the defendant's condition so that the defendant will continue treatment as prescribed or seek professional assistance as needed;
4. The grounds upon which the state relies for the proposed commitment;
5. Any past history that is relevant to establish the defendant's degree of conformity to the laws, rules, regulations, and values of society;
6. If the defendant's mental illness is in a state of remission, the medically suggested cause and degree of the remission, and the probability that the defendant will continue treatment to maintain the remissive state if the commitment conditions were to be altered.⁶

At a hearing held pursuant to sections [2945.401](#)(C) or (D)(1) or (2) of the Revised Code, the defendant shall have all of the rights of a defendant at a commitment hearing as described in section [2945.40](#). These rights are listed in [Appendix K](#).

At these hearings, the prosecutor has the burden of proof as follows (R.C. [2945.401\[G\]](#)):

1. For a recommendation of termination of commitment, to show by clear and convincing evidence that the defendant remains a mentally ill person subject to hospitalization by court order;
2. For a recommendation for a change in the conditions of the commitment to a less restrictive status, to show by clear and convincing evidence that the proposed change represents a threat to public safety or a threat to the safety of any person.

In a hearing held pursuant to this section, the prosecutor will represent the state or the public interest. At the conclusion of the hearing, the trial court may approve, disapprove, or modify the recommendation and shall enter an order accordingly.

Conditional Release: Pursuant to section [2945.402](#) of the Revised Code, if the trial court approves a conditional release, the court may set any conditions on the release with respect to the treatment, evaluation, counseling, or control of the defendant that the court considers necessary to protect the public safety and the welfare of the defendant.

A conditional release is a commitment. The hearings on continued commitment as described in section [2945.401](#) of the Revised Code apply to defendants on conditional release.

⁶ Based upon criteria in *In Re Burton*, 11 Ohio St. 3d 147

The RPH LAA and/or Forensic Monitor/designee should ensure that the court order clearly states or references the conditions of the release and allows communication between the involved individuals during the period of the conditional release commitment. The Forensic Monitor/designee shall ensure that the community treatment agency receives a copy of the court order and shall coordinate with the treating agency to prepare the required court reports. The LAA shall ensure that the Forensic Monitor receives a copy of the hospital's most recent HCR-20 risk assessment.

In accordance with section [5119.57](#) of the Revised Code, the Forensic Monitors are to report specified data to the Department of Mental Health on a quarterly basis. Please see the [Community Forensic Monitoring Program](#) section of this manual. Forensic Monitors should also consult the [Forensic Monitor Orientation Manual](#) for more detailed instructions on data submissions.

Conditional Release Revocation: Pursuant to section [2945.402](#) of the Revised Code, the trial court may revoke a defendant's conditional release and order rehospitalization or reinstitutionalization at any time the conditions of the release have not been satisfied, provided that the revocation shall be in accordance with that section.

A defendant who is on conditional release may be admitted to an ODMH RPH without a revocation of the conditional release. Under these circumstances, the person's legal status while in the hospital remains [2945.402](#). Please see the section on [Procedures for Hospitalization of People on Conditional Release](#) for more information about this process.

A person, agency or facility that is assigned to monitor a defendant on conditional release will immediately notify the trial court upon learning that the defendant being monitored has violated the terms of the conditional release. In almost all cases, it is the board-designated Forensic Monitor/designee who will notify the court of the violation. Upon learning of any violation, the court may issue a temporary order of detention or, if necessary, an arrest warrant for the defendant. Within ten court days after the defendant's detention or arrest, the court will conduct a hearing to determine whether the conditional release should be modified or revoked. At the hearing, the defendant will have the same rights as are described in section [2945.40\(C\)](#) of the Revised Code. The court may order a continuance of the ten-court-day period for no longer than ten days for good cause shown or for any period on motion of the defendant. If the court fails to conduct the hearing within the ten-court-day period and does not order a continuance in accordance with statute (R.C. [2945.402](#)), the defendant will be restored to the prior conditional release status.

The trial court will give all parties reasonable notice of a hearing conducted under section [2945.402](#) of the Revised Code. At the hearing, the prosecutor shall present the case demonstrating that the defendant violated the terms of the conditional release. If the court finds by a preponderance of the evidence that the defendant violated the terms of the conditional release, the court may continue, modify, or revoke the conditional release and will enter its order accordingly.

Competency Hearings for Persons with an IST-U-CJ Status: The trial court will hold a competency hearing if, at any time during the defendant's commitment under section [2945.39](#) of the Revised Code, there is cause to believe the defendant is competent to stand trial. The court may hold a hearing based on information contained in the periodic reports to the court made by

the RPH, facility or program to which the defendant is committed (as described under [Reporting Requirements](#), page 30). Also, if the prosecutor, the counsel for the defendant, or the department's designee/Chief Clinical Officer (CCO) of the RPH, facility, or program to which the defendant is committed files an application with the trial court alleging that the defendant presently is competent to stand trial and requests a hearing on the competency issue or if the trial court otherwise has reasonable cause to believe that the defendant presently is competent to stand trial and determines on its own motion to hold a hearing on the competency issue, the court will schedule a hearing on the competence of the defendant to stand trial. The trial court will give the prosecutor, the counsel for the defendant, and the chief clinical officer/department's designee notice of the date, time, and place of the hearing at least fifteen days before the hearing, and will conduct the hearing within thirty days of the filing of the application or of its own motion.

If at the conclusion of the hearing, the trial court determines that the defendant presently is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense, the court will order that the defendant is competent to stand trial, will be proceeded against as provided by law with respect to the applicable offenses described in section [2945.38\(C\)\(1\)](#) of the Revised Code, and will enter whichever of the following additional orders is appropriate:

1. If the court determines that the defendant remains a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the court will order that the defendant's commitment to the Department of Mental Health or, facility, or program be continued during the pendency of the trial on the applicable offenses described in section [2945.38\(C\)\(1\)](#).
2. If the court determines that the defendant no longer is a mentally ill person subject to hospitalization by court order, or a mentally retarded person subject to institutionalization by court order, the court will order that the defendant's commitment to the Department of Mental Health or, facility, or program will not be continued during the pendency of the trial on the applicable offenses described in section [2945.38\(C\)\(1\)](#). This order will be a final termination of the commitment for purposes of section [2945.401\(J\)\(1\)\(c\)](#).

If the trial court determines, at the conclusion of the competency hearing, that the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in his or her own defense, the court will order that the defendant continues to be incompetent to stand trial under criminal court jurisdiction. The court will continue the defendant's commitment to the Department of Mental Health or, facility, or program and the individual will remain under the jurisdiction of the court until the final termination of the commitment.

Termination of Commitment: Pursuant to section [2945.401\(J\)\(1\)](#) of the Revised Code, a defendant who has been committed as IST-U-CJ continues to be under the jurisdiction of the trial court until the final termination of the commitment. The final termination of a commitment occurs upon the earlier of one of the following:

1. The defendant no longer is a mentally ill person subject to hospitalization by court order, as determined by the trial court.

2. The expiration of the maximum prison term or term of imprisonment that the defendant could have received if the defendant had been convicted of the most serious offense with which the defendant was charged.
3. The defendant is found to be competent to stand trial and the trial court enters an order terminating the commitment under the conditions described in section [2945.401\(J\)\(2\)\(a\)\(ii\)](#), which is described above.

See [Appendix J](#) for Guidelines for Discharge of Persons on Conditional Release Commitment.

Procedures Following a Finding of Not Guilty by Reason of Insanity

Court Process: In accordance with section [2945.40](#) of the Revised Code, when an individual is found not guilty by reason of insanity (NGRI), the verdict will state that finding, and the trial court will conduct a full hearing to determine whether the individual is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order. Prior to the hearing, if the judge believes that there is probable cause that the individual found NGRI is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order, the judge may issue a temporary order of detention for that individual to remain in effect for ten court days or until the hearing, whichever comes first. Any person detained pursuant to such a temporary order of detention shall be held in a suitable facility (such as an ODMH RPH or other medical or psychiatric facility), taking into consideration the place and type of confinement prior to and during trial.

Failure to conduct the hearing within the ten court-day period shall cause the immediate discharge of the respondent, unless the judge grants a continuance for not longer than ten court days for good cause shown or for any period of time upon the motion of the respondent.

Rights: An individual who has been committed as NGRI has the right to attend all hearings conducted pursuant to sections [2945.37](#) to [2945.402](#) of the Revised Code. The court will inform the person of their additional rights in these proceedings. These rights are listed in [Appendix K](#).

The hearing under section [2945.40\(A\)](#) of the Revised Code will be open to the public and the court will conduct the hearing in accordance with the rules of civil procedure. The court will make and maintain a full transcript and record of the hearing procedure. The court may consider all relevant evidence, including, but not limited to, any relevant psychiatric, psychological, or medical testimony or reports, the acts constituting the offense in relation to which the person was found not guilty by reason of insanity, and any history of the person that is relevant to the person's ability to conform to the law. If the court finds that there is not clear and convincing evidence that the person is a mentally ill person subject to hospitalization, the person will be discharged. If a detainer has been placed upon the person by the [Department of Rehabilitation and Correction](#), the person shall be returned to that department.

If the court finds by clear and convincing evidence that the person is a mentally ill person subject to hospitalization by court order the court will commit the person either to the Department of Mental Health for treatment in a hospital, facility, or agency as determined clinically appropriate by ODMH or to another medical or psychiatric facility, as appropriate. If the court determines by

clear and convincing evidence that the person requires treatment for mental retardation, it will commit the person to a facility operated by the [Department of Developmental Disabilities](#), or another facility, as appropriate. All further proceedings will be in accordance with sections [2945.401](#) and [2945.402](#) of the Revised Code. In determining the place of commitment, the court will consider the extent to which the person is a danger to the person and to others, the need for security, and the type of crime involved and will order the least restrictive alternative available that is consistent with public safety and the welfare of the person. In weighing these factors, the court will give preference to protecting public safety.

The court may commit the person to an Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or a Community Mental Health (CMH) Board, or to a community mental health agency, and place the individual on conditional release in the community pursuant to section [2945.402\(A\)](#) of the Revised Code. The person remains under the trial court's jurisdiction, is monitored in the community by the Forensic Monitor for the ADAMHS/CMH Board of the county of the committing court, and receives mental health services from the community mental health agency. The person will remain under the court's jurisdiction until the termination of the commitment as described in section [2945.401 \(J\)](#) of the Revised Code.

Admission Criteria: If the court finds by clear and convincing evidence that the person is a mentally ill person subject to hospitalization by court order, it may commit the person to ODMH.

A person who is committed pursuant to this Section shall not be voluntarily admitted to a RPH or institution pursuant to sections [5122.02](#), [5122.15](#), [5123.69](#) or [5123.76](#) of the Revised Code.

Court Documents: The place of commitment will receive a copy of the court order from the trial court stating that the person was found NGRI and mentally ill and subject to hospitalization. The court will also send a copy of the indictment or complaint and a copy of each examiner's report and any other information that the court deems relevant. The prosecutor will send to the place of commitment all reports of the person's current mental condition and any other relevant information, including but not limited to, a transcript of the hearing held pursuant to section [2945.40\(A\)](#) of the Revised Code, copies of relevant police reports, and copies of any prior arrest and conviction records that pertain to the person and that the prosecutor possesses.

The prosecutor will send the reports of the person's current mental condition in every case of commitment, and unless the prosecutor determines that the release of any of the other relevant information to unauthorized persons would interfere with the effective prosecution of any person or would create a substantial risk of harm to any person, the prosecutor will send the other relevant information.

The RPH Legal Assurance Administrator (LAA) should attempt to obtain as much collateral information as possible to assist in the preparation of evaluations, social histories, violence risk assessments, and treatment plans.

Criminal Charge: An NGRI verdict has the same effect as a verdict of "not guilty" in that the person cannot be further prosecuted for the same criminal conduct for which the person was found NGRI.

Community Notification Requirements: When an individual is committed to ODMH as NGRI and admitted to an ODMH RPH, the LAA will notify the ADAMHS or the CMH Board for the

County of the Committing Court about the admission. The LAA will send to the Board a copy of all reports of the person's current mental condition; a copy of all relevant information provided by the prosecutor (see above), including, if provided, a copy of the transcript of the hearing held pursuant to section [2945.40\(A\)](#) of the Revised Code; the relevant police reports; and the prior arrest and conviction records that pertain to the person and that the prosecutor possesses. If the individual is directly committed by the court to a community agency, the agency will send the above documents to the ADAMHS or CMH Board for the County of the Committing Court.

Reporting Requirements: The RPH LAA, or a person with similar duties in another facility or program, will ensure that a written report is submitted to the trial court at the end of the initial six months of treatment and every two years after the initial report. The report will indicate if the individual remains a mentally ill person subject to hospitalization by court order. The court will give copies of the report to the prosecutor and defense counsel. Within thirty days after receipt of a report from the RPH or other facility or program the trial court will hold a hearing on the continued commitment of the individual, or regarding any changes in the conditions of the commitment. If the individual requests a change in the conditions of commitment, the trial court will conduct a hearing on that request if six months or more have elapsed since the most recent hearing was conducted under section [2945.401\(C\)](#) of the Revised Code.

Movement - Level 2

An individual who is in an NGRI status, committed to ODMH and placed at an RPH, remains under the trial court's jurisdiction. Patients charged with aggravated murder, murder, or felony 1 or felony 2 offenses must have approval by the RPH treatment team and the RPH Forensic Review Team (FRT) prior to granting Level 2 movement. Patients charged with lesser offenses are allowed Level 2 (Supervised, On Grounds Movement) after review and approval by only the RPH treatment team.

Movement - Levels 3 and 4

Prior to a request for an additional movement level, the treatment team will review all risk assessments that have been conducted on the individual, and will conduct a current risk assessment update. After evaluation of the risks to public safety along with consideration of the welfare of the patient, their recommendation for movement will be forwarded to the RPH Forensic Review Team (FRT). The FRT will review all movements of patients with an NGRI status prior to movement of Level 3 or above. If the FRT is in agreement, the request will be sent to the RPH CCO.

The department's designee/CCO will review the request for movement and the related documents. If the department's designee/CCO is in agreement, an application will be filed with the trial court for approval of On-Grounds, Unsupervised Movement (Level 3), or Off-Grounds, Supervised Movement (Level 4). A copy of the application for approval of movement will be sent to the prosecutor. If the prosecutor does not request a hearing within 15 days, the trial court either approves the department's designee's/CCO request or may hold a hearing on its own accord within 30 days. If the prosecutor requests a hearing, the court must hold a hearing within 30 days of the request, and the court must notify the prosecutor 15 days prior to the hearing date. The court will make a decision regarding the request for movement, and will enter its order accordingly. See the Movement Policy (MF-04) in [Appendix D](#).

At any time after evaluating the risks to public safety and the welfare of the person, the department's designee/CCO may recommend a termination of the commitment or a change in the conditions of the commitment (R.C. [2945.401\(D\)\(1\)](#)).

Nonsecured Status: Level 5 Movement, Off Grounds, Unsupervised; Trial Visit; or Conditional Release

A nonsecured status is defined as any unsupervised off-grounds movement, trial visit from an RPH or institution, or conditional release, that is granted to a person who has been committed under section [2945.39](#) (IST-U-CJ) or [2945.40](#) (NGRI) of the Revised Code. The RPH treatment team and FRT review process for this movement level is the same as that required prior to requesting a Level 3 or 4 movement. When the treatment team and the FRT are in agreement that the individual should be granted the first nonsecured status, the request is sent to the CCO.

The department's designee/CCO will review the related information and if in agreement with the request, will send written notification of this recommendation to the trial court and the local Community Forensic Psychiatry Center. (The "local" Forensic Center refers to the center that serves the county in which the criminal charges were filed). Included in the notification is the request for a Nonsecured Status ("second opinion") evaluation of the patient by a Forensic Center examiner and the conditional release plan when the request is for conditional release. The RPH LAA shall coordinate this process and ensure that the appropriate documentation is sent. A separate entry from the court is not required. Some RPHs have developed forms to notify the court of the recommendation of the department's designee/CCO and simultaneously request a second opinion evaluation. (See [Appendix F](#) for a sample notification form.)

The Community Forensic Psychiatry Center will conduct a Nonsecured Status evaluation of the individual at the RPH and within thirty days after receiving the notification will send a written report to the department's designee/CCO and the trial court. The court will provide a copy of the department designee's/CCO's written notice and the Forensic Center's written report to the prosecutor and the counsel for the defendant. Upon the submission of the Nonsecured Status evaluation report to the trial court and the department's designee/CCO, all of the following apply:

1. If the Forensic Center disagrees with the recommendation of the department's designee/CCO, the Forensic Center will inform the department's designee/CCO and the trial court of the disagreement and the reasons for the decision. The department's designee/CCO, after consideration of the Forensic Center's decision, will either withdraw, proceed with, or modify and proceed with the recommendation. If the department's designee/CCO proceeds with, or modifies and proceeds with the recommendation, the department's designee/CCO will proceed in accordance with section [2945.401\(D\)\(1\)\(b\)\(iii\)](#) of the Revised Code. (See Number 3 below).
2. If the Forensic Center agrees with the recommendation of the department's designee/CCO, it will inform the department's designee/CCO and the court of this decision and the reasons for the decision. The department's designee/CCO will proceed as indicated below.
3. If the Forensic Center disagrees with the recommendation of the department's designee/CCO, and the department's designee/CCO proceeds with or modifies and proceeds with the recommendation, or if the Forensic Center agrees with the

recommendation of the department's designee/CCO, the department's designee/CCO or designee will work with the ADAMHS or CMH Board for the County of the Committing Court (county where the charges were filed) to develop a plan to implement the recommendation. The board-designated community Forensic Monitor and the community mental health service provider should work with the RPH staff to develop this plan. If the recommendation is for conditional release, the conditional release (CR) plan will identify the specific conditions that the individual is required to follow in the community. The CR plan will also include the steps to be taken and the parties responsible to carry out those steps if the person violates the conditions of the plan. (See [Appendix J](#) for the Conditional Release Plan Guidelines). If the person is on medication, the plan will include, but not be limited to, a system to monitor the person's compliance with the prescribed medication treatment plan. The plan/system will include a schedule that clearly states when the person reports for medication compliance checks. The medication compliance checks will be based on the effective duration of the prescribed medication, taking into account the route by which it is taken, and will be scheduled at intervals sufficiently close together to detect a potential increase in mental illness symptoms that the medication is intended to prevent (R.C. [2945.401\[D\]\[1\]\[b\]\[iii\]](#)).

The department's designee/RPH CCO, after consultation with the ADAMHS or CMH Board, will send the recommendation and written plan to the trial court, the prosecutor and the person's defense counsel. The trial court will conduct a hearing on the recommendation and plan. In accordance with section [2945.401\(D\)\(1\)\(c\)](#) and (d) and (E) to (J) of the Revised Code, the following applies to these hearings:

1. If the department's designee/CCO's recommendation is for nonsecured status or termination of the commitment, the prosecutor may obtain an independent expert evaluation of the person's mental condition, and the court may continue the hearing on the recommendation for a period of not more than 30 days to permit time for the evaluation. The prosecutor may introduce the evaluation report or present other evidence at the hearing in accordance with the rules of evidence.
2. The court will schedule the hearing on the department's designee/CCO's recommendation for nonsecured status or termination of commitment and will give reasonable notice to the prosecutor and the person's defense counsel. Unless continued for independent evaluation at the prosecutor's request or for other good cause, the hearing will be held within 30 days after the court's receipt of the recommendation and plan.

The trial court, in making a determination regarding nonsecured status or termination of commitment, will consider all relevant factors including, but not limited to, all of the following:

1. Whether, in the trial court's view, the person currently represents a substantial risk of physical harm to the person or others;
2. Psychiatric and medical testimony as to the current mental and physical condition of the person;
3. Whether the person has insight into the person's condition so that the person will continue treatment as prescribed or seek professional assistance as needed;

4. The grounds upon which the state relies for the proposed commitment;
5. Any past history that is relevant to establish the person's degree of conformity to the laws, rules, regulations, and values of society;
6. If the person's mental illness is in a state of remission, the medically suggested cause and degree of the remission, and the probability that the person will continue treatment to maintain the remissive state if the commitment conditions were to be altered.⁷

At any hearing held pursuant to section [2945.401](#)(C) or (D)(1) or (2) of the Revised Code, the person will have all of the rights of a person at a commitment hearing described in section [2945.40](#) (see [Appendix K](#)).

At these hearings, the prosecutor has the burden of proof as follows (R.C. [2945.401\[G\]](#)):

1. For a recommendation of termination of commitment, to show by clear and convincing evidence that the person remains a mentally ill person subject to hospitalization by court order;
2. For a recommendation for a change in the conditions of the commitment to a less restrictive status, to show by clear and convincing evidence that the proposed change represents a threat to public safety or a threat to the safety of any person.

In a hearing held pursuant to this section, the prosecutor shall represent the state or the public interest. At the conclusion of the hearing, the trial court may approve, disapprove, or modify the recommendation and will enter an order accordingly.

Conditional Release: Pursuant to section [2945.402](#) of the Revised Code, if the trial court approves a conditional release, the court may set any conditions on the release with respect to the treatment, evaluation, counseling, or control of the person that the court considers necessary to protect the public safety and the welfare of the person.

A conditional release is a commitment. The hearings on continued commitment as described in section [2945.401](#) of the Revised Code apply to persons on conditional release.

The RPH LAA and/or Forensic Monitor should ensure that the court order clearly states or references the conditions of the release and allows communication between the involved individuals during the period of the conditional release commitment. The Forensic Monitor/designee shall ensure that the community treatment agency receives a copy of the court order and shall coordinate with the treating agency to prepare the required court reports. The RPH LAA will ensure that the Forensic Monitor receives a copy of the hospital's most recent HCR-20 risk assessment.

In accordance with section [5119.57](#) of the Revised Code, the Forensic Monitors are to report specified data to the Department of Mental Health on a quarterly basis. Please see the [Community Forensic Monitoring Program](#) section of this manual for additional information on

⁷ Based upon criteria in *In Re Burton*, 11 Ohio St. 3d 147 (1984)

this process. Forensic Monitors should also consult the [Forensic Monitor Orientation Manual](#) for more detailed instructions on data submissions.

Conditional Release Revocation: Pursuant to section [2945.402](#) of the Revised Code, the trial court may revoke a person's conditional release and order rehospitization or reinstitutionalization at any time if the conditions of the release have not been satisfied, provided that the revocation will be in accordance with that section.

A person who is on conditional release may be admitted to an ODMH RPH without a revocation of the conditional release. Under these circumstances, the person's legal status while in the hospital remains [2945.402](#). Please see [Guidelines for Hospitalization](#) for more information about this process.

A person, agency or facility that is assigned to monitor a person on conditional release will immediately notify the trial court upon learning that the person being monitored has violated the terms of the conditional release (R.C. [2945.402\[C\]](#)). In almost all cases, it is the board-designated Forensic Monitor/designee who will notify the court of the violation. Upon learning of any violation, the court may issue a temporary order of detention, or if necessary, an arrest warrant for the person. Within ten court days after the person's detention or arrest, the court will conduct a hearing to determine whether the conditional release should be modified or terminated. At the hearing, the person will have the same rights as are described in section [2945.40\(C\)](#) of the Revised Code. The court may order a continuance of the ten-court-day period for no longer than ten days for good cause shown or for any period on motion of the person. If the court fails to conduct the hearing within the ten-court-day period and does not order a continuance in accordance with statute (R.C. [2945.402](#)), the person will be restored to the prior conditional release status.

The trial court will give all parties reasonable notice of a hearing conducted under section [2945.402](#) of the Revised Code. At the hearing, the prosecutor will present the case demonstrating that the person violated the terms of the conditional release. If the court finds by a preponderance of the evidence that the person violated the terms of the conditional release, the court may continue, modify or revoke the conditional release and will enter its order accordingly.

Termination of the Commitment: Pursuant to section [2945.401\(J\)\(1\)](#) of the Revised Code, a person who has been committed as NGRI continues to be under the jurisdiction of the trial court until the final termination of the commitment. The final termination of a commitment occurs upon the earlier of one of the following:

1. The person no longer is a mentally ill person subject to hospitalization by court order, as determined by the trial court.
2. The expiration of the maximum prison term or term of imprisonment that the individual could have received if the individual had been convicted of the most serious offense with which the individual was charged, or in relation to which the individual was found not guilty by reason of insanity. (See Guidelines for Discharge of Persons on Conditional Release Commitment in [Appendix J](#)).

The maximum time of the commitment for a person found NGRI is calculated from the date of the NGRI finding. Time that is served in jail prior to the NGRI finding cannot be used to reduce the maximum time of commitment ([State v. Tuomala](#), 104 Ohio St.3d 93, 2004).

Parolees and Probationers

A mentally ill offender who is under the custody of the Ohio Department of Rehabilitation and Correction (ODRC) and released on parole or probation, is subject to hospitalization at an ODMH Regional Psychiatric Hospital (RPH). A responsible party may file an affidavit with the probate court, or the individual's parole/probation officer, or the individual can voluntarily seek admission. If the parole/probation officer files an affidavit, the commitment is pursuant to section [2967.22](#) of the Revised Code. If a person other than the parole/probation officer files the affidavit or if the patient voluntarily seeks admission, the admission is pursuant to chapter [5122](#) of the Revised Code.

Admission Criteria: When a mentally ill parolee or probationer is admitted to a facility operated by the Department of Mental Health, all of the court proceedings are civil proceedings in the probate court as provided by chapter [5122](#) of the Revised Code. The individual must have a pre-hospitalization screening assessment completed by the designated agency for the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or a Community Mental Health (CMH) Board for the County of Legal Residence (the county of the person's usual residence).

Rights and Movement: Offenders who are on parole or probation and involuntarily committed for treatment can be granted Movement Levels 1 through 5 according to the ODMH Movement Policy. See Appendix D for the [Movement Policy \(MF-04\)](#). Parolees and probationers who are voluntarily committed have the same movement rights as any voluntary patient.

If the person is admitted pursuant to section [2967.22](#) of the Revised Code, the RPH staff can share information with the offender's parole or probation officer without a signed release from the offender. When the individual is admitted under a voluntary status, the RPH staff is required to request the patient's authorization prior to sharing of information with the parole or probation officer. If the patient consents, the LAA shall notify the parole or probation officer before the individual is granted Level 5—Nonsecured Status.

The RPH staff *must* notify the parole or probation officer of any occurrence of Absent Without Leave (AWOL) involving the individual when admission status is pursuant to section [2967.22](#).

Credit for Time: The offender shall be given credit against his/her period of parole or probation for all time spent in the RPH.

Discharge: The offender may be discharged when it is determined that there is no longer a need for hospitalization. When the individual is admitted under section [2967.22](#) of the Revised Code and provides consent the parole or probation officer shall be notified prior to discharge and may provide assistance in the development of the post discharge plan. The probate court should be notified of the offender's discharge when the offender is civilly committed.

Jail Transfer

When an individual is incarcerated in a jail and requires inpatient hospitalization, the jail administrator should initiate the process for pre-hospitalization screening. The pre-hospitalization screening will be conducted by the identified agency of the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or the Community Mental Health (CMH) Board for the County of Legal Residence (the county of the person's usual residence). If the individual meets the criteria for hospitalization and refuses voluntary admission, the person may be hospitalized through emergency procedures and, if necessary an affidavit will be subsequently filed with the probate court for involuntary admission.

Rights and Movement: Persons admitted to an RPH as a Jail Transfer are not permitted movement above Level 1 in accordance with the Movement Policy (MF-04; see [Appendix D](#)).

Discharge: If after the initial examination, or at any time thereafter, the RPH CCO or designee finds the inmate not to be a mentally ill person subject to hospitalization by court order, or no longer needs inpatient care, the police or other law enforcement entity will be notified that the individual is ready for discharge. The LAA/designee will verbally notify the law enforcement agency, and if there is no response, notification by certified mail, return receipt requested, will be made. The law enforcement staff is responsible to pick up the individual, unless written information is sent to the RPH from the jail that indicates that the person is no longer under their custody, in which case, the person shall be discharged.

Police Hold

At times, an individual may be taken into custody by a law enforcement officer, and subsequently transported to a mental health facility or an ODMH RPH for a mental health assessment or mental health treatment. No criminal charges will have been filed at the time the individual is brought in for services.

The agency specified by the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or the Community Mental Health (CMH) Board for the County of Legal Residence (the county of the person's usual residence) is responsible for the pre-hospitalization screening assessment. If the individual meets the criteria for hospitalization and refuses voluntary admission, the person may be hospitalized through emergency procedures, and if necessary an affidavit will be subsequently filed with the probate court for involuntary admission.

Rights and Movement: Persons admitted to an RPH as a Police Hold are not permitted movement above Level 1 in accordance with the Movement Policy (MF-04; see [Appendix D](#)).

Discharge: When the individual meets the criteria for discharge from the RPH as determined by the RPH CCO or designee, the police or other law enforcement entity will be notified that the individual is appropriate for discharge. The LAA/designee will verbally notify the law enforcement agency, and if there is no response, notification by certified mail, return receipt requested, will be made. The law enforcement staff are responsible to pick up the individual, unless written information is sent to the RPH from the jail that indicates that the person is no longer under their custody, in which case, the person will be discharged.

Department of Youth Services

The Department of Youth Services (DYS) may request inpatient services for persons in their custody who are between the ages of 18 to 21. Please refer to [Appendix L](#) for the Admission Procedures for Referrals from DYS.

Department of Developmental Disabilities

ODMH and the Department of Developmental Disabilities (DODD) frequently serve individuals who have a forensic legal status and who are diagnosed with both a serious mental illness and an intellectual disability (MI-DD). Several years ago, in an effort to increase collaboration between the two systems that serve people with MI-DD who are on Conditional Release, the DODD distributed a memorandum to their county DD Boards describing the role of the Forensic Monitor ([Appendix Y](#)). The monitors work with all people on conditional release regardless of whether they receive services from the mental health system, the mental retardation system or both. This memorandum helps to clarify this part of the Forensic Monitors' role.

COMMUNITY FORENSIC SERVICES

Since the early to mid-1990s, Ohio has seen an increase in the variety of community-based services offered to individuals who are mentally ill and involved in the criminal justice system. This increase in the array of services has occurred as a result of legislative requirements and collaborative efforts between ADAMHS/CMH Boards and service providers. These services support the provision of treatment in the least restrictive setting, with an emphasis on the assessment and management of violence risk to ensure public safety, and an increased focus on the recovery of persons with a forensic status.

In this section of the Manual, information is presented on the following community-based services and programs: the Community Forensic Monitoring Program, the Community Linkage Program, and Mental Health Diversion Alternatives.

Community Forensic Monitoring Program

Introduction

The position of Forensic Monitor was formally created in 1996 as a result of House Bill 152 and became further defined with the enactment of Senate Bill 285, which became effective in 1997. Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board and Community Mental Health (CMH) Board in Ohio is responsible to ensure that a Forensic Monitor is providing certain services for their board area. The Forensic Monitor may be employed by one Board or a consortium of Boards, by a community mental health agency, by a Community Forensic Psychiatry Center, or by a Community Support Network (CSN). Frequently, the Forensic Monitors have additional duties along with their monitoring responsibilities and/or another person may act as designee for the Forensic Monitor by performing many of the monitoring duties.

Forensic Monitors should consult [Appendix J](#) of this manual and the [Forensic Monitor Orientation Manual](#) located on the [ODMH website](#) for additional information about fulfilling their roles.

As described later in this section, all of the *required* Forensic Monitor duties are administrative. However, it is recommended that the monitor have a strong clinical background and knowledge of forensic mental health treatment. The Forensic Monitor plays a crucial role as the liaison among the individual, the court, the Boards, the community providers, and the Regional Psychiatric Hospitals (RPHs). The monitor needs to be knowledgeable about the criminal justice system, court proceedings, forensic statutes, the RPH procedures, community mental health treatment, and most importantly, risk management principles and methods to ensure public safety.

Value Statement

The Community Forensic Monitoring Program values the provision of mental health services in the least restrictive treatment setting, with a priority of public safety that is supported through

regular risk assessment and risk management practices and through utilization of available evidence-based practices and implementation of the Recovery Model.

Forensic Monitoring Program Components

The Forensic Monitor is responsible to monitor persons found by a court to be Not Guilty by Reason of Insanity (NGRI; R.C. [2945.40](#)) or Incompetent to Stand Trial—Unrestorable—under Criminal Court Jurisdiction (IST-U-CJ; R.C. [2945.39](#)) and who have been granted conditional release (CR). The Forensic Monitor or designee also serves as a forensic resource for ADAMHS/CMH Boards, community mental health agencies, Community Forensic Psychiatry Centers, ODMH RPHs, and the criminal justice system. In collaboration with the board, the Forensic Monitor provides education, training, consultation, liaison services, collects data, and compiles required reports.

The Forensic Monitor is typically involved with an individual prior to release from an ODMH RPH. Beginning at the time when the patient is granted Level 3 movement, the Forensic Monitor participates in the development of the CR plan with the patient, RPH treatment team, and the community mental health service provider, as indicated. The exception to this practice occurs when an individual is released directly from the court to CR in which case the RPH staff would not be involved. (See the section on [Conditional Release Commitment Directly from Court](#) on page 54).

When the court grants CR, the RPH LAA and Forensic Monitor should ensure that the conditional release court order clearly states or references the conditions of the release and allows communication among all of the individuals and entities involved in carrying out the CR plan during the period of the CR commitment. The RPH LAA shall ensure that the Forensic Monitor receives a copy of the hospital's most recent HCR-20 risk assessment. The LAA shall also send a copy of the final CR plan to all signatories of the plan including the ADAMHS/CMH Board(s) that are involved with the case, whether or not the Board(s) sign the plan. If the person on CR is not being released from an RPH, the Forensic Monitor shall send a copy of the final CR plan to all signatories of the plan, including the ADAMHS/CMH Board(s) that are involved with the case, whether or not the Board(s) sign the plan.

The Forensic Monitor shall do everything possible to ensure that the community treatment agency is made aware of all of the requirements of the CR plan and their responsibilities when the person on CR violates any requirement on the CR plan. The Forensic Monitor shall coordinate with the treating agency to prepare the required court reports. The Forensic Monitor maintains regular contact with the community mental health providers to monitor the person's progress and to ensure that the community risk assessment instrument is being completed as recommended in the guideline (see [Appendix M](#)). The monitor also ensures that the court is informed about the individual's status and that all required reports are sent to the court. The monitor shall attend the mandatory two-year hearings (and six-month hearing, if applicable) following the conditional release commitment and shall provide the court with information as requested.

Section [5119.57](#) of the Revised Code requires that a coordinated system be developed to track and monitor persons who are found NGRI or IST-U-CJ and are on CR. This system is known as the Forensic Tracking and Monitoring System (FTMS). The Forensic Monitors are required to

complete quarterly reports on these individuals and provide designated information to ODMH, Office of Forensic Services (OFS). Additional information about data submission is included in the [Forensic Monitor Orientation Manual](#).

The Forensic Monitor monitors individuals granted CR who have been charged with either felony or misdemeanor offenses through Common Pleas and Municipal/County Court systems. The monitor needs to be aware that the time requirements for the Municipal Court proceedings are different than those for the Common Pleas Courts. FTMS data must be submitted on all individuals on CR regardless of whether they are under the jurisdiction of the Common Pleas or Municipal/County court.

On a regular basis, the Forensic Monitors convene as a group with staff from OFS, the ODMH RPH Legal Assurance Administrators (LAAs), other ODMH office representatives, and other invited guests from the judicial system, the community mental health service provider system, and other state departments. The function of these meetings is to encourage communication and education among members, to identify and resolve problems, and to support the development of standardized monitoring practices. Subcommittees from the larger group have developed and formalized the Guidelines for Forensic Monitor Duties, the Forensic Monitor Orientation Manual, the Community Risk Assessment of Persons on Conditional Release, the Forensic Tracking and Monitoring System Guidelines, and the Conditional Release Report Guidelines, all of which are included in this manual or on the [ODMH website](#).

Community Forensic Principles

1. The Board serving the County of the Committing Court (i.e., the county where the charges were filed) for a person committed as Not Guilty by Reason of Insanity (NGRI) or Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction (IST-U-CJ) and on Conditional Release (CR) is financially and programmatically responsible for the person until the individual's CR is terminated by the court. Persons should be placed in their home communities when possible and practical. Two involved Boards can reach agreement about payment of services when the court has approved the person residing outside of the county of the committing court. For a draft agreement, see [Appendix Q](#).
2. Each Board, or a consortium of Boards, will designate a Forensic Monitor to be responsible for coordinating forensic cases and monitoring persons on CR. Each Board or its designee must plan and coordinate services with the RPH, community providers, and the criminal justice system for persons found NGRI or IST-U-CJ and other identified forensic persons⁸. Forensic monitoring services must be available in each Board area. The Board, or representative of a consortium of Boards, is responsible to notify the Office of Forensic Services at ODMH when the Forensic Monitor changes.
3. Early and ongoing involvement of the Boards and community providers with the criminal justice system is essential for effective treatment, discharge planning, risk management, and provision of appropriate services. The RPH LAA shall notify the Forensic Monitor, Board and community agency when a patient is granted Level 3 Movement in order to facilitate their early involvement. Each Board is encouraged to designate an agency as the primary service provider for clients with a forensic legal status.

⁸ These persons could include former prison inmates and other high-risk individuals identified by the Board.

4. The court is a primary partner and has ultimate decision-making authority when serving persons found IST-U-CJ and NGRI.
5. NGRI acquittees and persons found IST-U-CJ, like others with mental illness, should have access to a continuum of care that provides a broad range of services and supports that are culturally appropriate and based on individual treatment needs. These services may be provided by a variety of service systems.
6. Treatment planning should be driven by the circumstances of the offense, community safety, clinical needs, recent risk assessments, and the current conditions outlined in the conditional release plan. Regular review and update of the treatment plan should continue to address the offense, the person's mental health status and compliance with the conditional release plan, and additional factors as outlined below.
 - a. Collateral information should be used in addition to the person's account of the offense and incorporated into the treatment plan as appropriate.
 - b. The circumstances of the offense should be explicitly considered in release recommendations and addressed as necessary in the treatment planning process
 - c. Risk management criteria should always be addressed, especially when developing and updating the treatment plan:
 - Whether the person represents a substantial risk of physical harm to self or others;
 - Attention to the current status of the person's mental and physical condition and any significant changes to either;
 - The person's insight into his/her condition, including compliance with treatment as prescribed and whether the person will seek professional assistance if needed;
 - As appropriate and necessary, the grounds upon which the state relies for commitment;
 - Any past history that is relevant to establish the person's degree of conformity to the laws, rules, regulations, and values of society; current behavior or concerns related to any of these areas;
 - If there is evidence that the person's mental illness is in a state of remission, the probability that the person will continue treatment to maintain the remissive state if considering a recommendation that the commitment conditions be altered.⁹
7. There must be a process in place to allow prompt rehospitalization or reinstitutionalization when a lesser restrictive alternative is inappropriate, unavailable, or does not protect public safety or the safety of the person on conditional release. The Forensic Monitor must be aware of this process and know how to quickly implement this process when necessary.
8. NGRI acquittees and persons found IST-U-CJ should participate in treatment planning and have the right to make decisions regarding treatment options within the parameters and restrictions imposed by the court. Confidentiality should be considered and every effort to

⁹ Based upon criteria in *In Re Burton*, 11 Ohio St. 3d 147 (1984)

involve the individual's family and significant others in the treatment planning process should be made, within the restrictions imposed by the court. Treatment planning for conditional release shall include consideration of risk assessment(s), public safety, clinical appropriateness, and any restrictions imposed by the court.

9. Violence risk assessment and risk management should be a central part of treatment and monitoring. The Forensic Monitor should be involved in the risk management process. For persons who have a potential for dangerous behavior and present relevant risk factors, treatment plans must encompass risk management plans. Identified risk factors must be periodically reassessed, and continually monitored to decrease the probability of a repeated violent or dangerous act.
10. The Forensic Tracking and Monitoring System (FTMS) for persons found NGRI and IST-U-CJ on conditional release has been established to include data collected from both the mental health system and the criminal justice system. Board areas are encouraged to develop local centralized tracking systems with local criminal justice agencies.

Forensic Monitor/Designee Duties

1. ***The Forensic Monitor or designee shall participate with both Regional Psychiatric Hospitals (RPH) and community treatment providers in planning and coordinating services for persons found NGRI or IST-U-CJ.***

Required duties:

- a. Interacting with the RPH Legal Assurance Administrator (LAA) regarding case status.
- b. Serving as liaison between the courts/criminal justice system, the LAA and other RPH staff, community treatment providers, and ADAMHS/CMH boards.
- c. Involvement in the development of the conditional release plan, including participation with the RPH treatment staff in the development of the conditional release plan prior to discharge.
- d. Meeting with community provider treatment teams and/or case managers to develop and implement the person's conditions of release.
- e. Monitoring treatment provided to the person by the service provider in accordance with the conditional release plan and the orders of the court.
- f. Monitoring reports of the person's criminal activity.

Optional duties (include but are not limited to):

- g. Maintaining regular direct contact with the person on CR while in a community setting. (This direct contact should occur only after any conflict of interest issues have been addressed.)
- h. Interacting with the RPH Forensic Review Team regarding conditional release readiness.

- i. Making recommendations for treatment to assist in the development of conditional release plans.

2. *The Forensic Monitor or designee shall interact with the Criminal Court.*

Required duties:

- a. Attending hearings following a conditional release commitment.
- b. Reporting compliance with conditional release plans as required by the court.
- c. Immediately reporting to the court any violations of the terms of conditional release or deterioration in the individual's mental status.
- d. Initiating or participating in legal and/or administrative procedures, if necessary, to facilitate hospitalization, institutionalization, or incarceration of the person who is on conditional release.
- e. Ensuring that required reports for persons on conditional release are submitted to the court.
- f. Reporting information regarding court hearing outcomes to treatment providers and, when appropriate, the RPH LAA. Upon the termination of the commitment of a person who has been released from an RPH, the Forensic Monitor shall notify the LAA of this termination.
- g. For those persons found NGRI or IST-U-CJ and released directly to the community from the court, developing a mechanism to identify these persons, and working with the court and treatment providers to develop and implement conditional release plans for them.

Optional duties:

- h. Providing advice and consultation to the court about required hearings and other time lines as requested by the court. (NOTE: Each court may have different expectations for this duty, so it is recommended that the monitor work with the judge and/or the court administrator to jointly develop procedures.)

3. *The Forensic Monitor or designee shall work with the ADAMHS/CMH Boards, which are responsible for developing community services for persons found NGRI or IST-U-CJ.*

Required duties:

- a. Notifying the Board of major unusual incidents and violations of the conditional release terms as determined by the Board.
- b. Preparing statistical or narrative reports as required by the Board.

- c. In conjunction with Board staff, assisting in out-of-county service planning, including monitoring responsibility for those services.
- d. Providing training to Board members and staff on forensic issues.
- e. Consulting with the Board on forensic policy and procedure development and implementation.
- f. Working with the Board to develop and implement effective community risk management policies and procedures for persons on conditional release.

4. *The Forensic Monitor or designee shall cooperate with the Ohio Department of Mental Health.*

Required duties:

- a. Assisting in the ongoing implementation of the Forensic Tracking and Monitoring System (FTMS).
- b. Sending required quarterly FTMS reports to Office of Forensic Services, ODMH.
- c. Reporting to OFS any instances in which the monitor experiences difficulty obtaining requested reports from the treating agency or is unable to have a court schedule a mandated two-year hearing.
- d. Attending statewide Forensic Monitor meetings.
- e. Participating on subgroups to further the development of the statewide Forensic Monitor Program, including making recommendations on policy, procedure and guidelines as necessary.

Hospitalization/Detention of Persons on Conditional Release

Persons found NGRI or IST-U-CJ placed on conditional release (CR) remain under a criminal court commitment. These individuals are monitored by the Forensic Monitor as assigned by the ADAMHS/CMH Board for the County of the Committing Court (county where the charges were filed).

At times, an individual on CR may experience difficulty in the community and may require inpatient psychiatric services. A person on conditional release may be hospitalized for a number of reasons, including, but not limited to the following: acute symptoms of mental illness, medication adjustment problems, situational crises resulting in instability or increased violence risk, or a violation of one or more conditions that are contained in the CR plan.

Guidelines for Emergency Hospitalization. If it becomes apparent to the community service provider or the Forensic Monitor that an individual on conditional release may be appropriate for inpatient mental health services, the procedures to be followed are much the same as for any

individual who is experiencing a psychiatric crisis. In most cases, the community service provider or the Forensic Monitor will assist in arranging for a pre-hospitalization screening by the designated agency. A family member or other concerned party may also seek psychiatric emergency services for the individual or the individual may seek services independently. If the individual meets the criteria for hospitalization, the individual can be admitted to an ODMH RPH or another psychiatric facility as designated by the local ADAMHS/CMH Board.

The Forensic Monitor shall coordinate with the local ADAMHS/CMH Board or the designated pre-hospitalization screening agency to develop a system that will assist in identifying individuals who are on CR and appear for emergency psychiatric services and/or may be hospitalized. The monitor and community service provider shall ensure that both are informed about the individual's status in these situations. It is the responsibility of the Forensic Monitor to notify the court in writing and the Board (for the Committing County) if the individual is hospitalized.

The Forensic Monitor shall advise the court of the circumstances of the hospitalization and recommend a course of action if requested by the judge. In most cases, if the person needs a short-term hospitalization for stabilization of symptoms of mental illness, the CR would not be revoked. Generally, if the person needs to be hospitalized for a violation of the CR plan, then the CR would be revoked. (See below for more detail.) The court may choose not to revoke the CR but rather amend the conditional release order to provide for temporary hospitalization until it is determined that the individual is appropriate to return to the community. The court may also choose to revoke the conditional release before admission or at any time. In either case, when the individual is hospitalized, the Forensic Monitor shall continue to monitor the individual's progress. When a person on CR is hospitalized in an RPH the Forensic Monitor will work with the Legal Assurance Administrator (LAA) to coordinate discharge plans. As appropriate, the community treatment provider should continue to have contact with the individual during hospitalization.

If the person is hospitalized for a short term, and the conditional release is *not* revoked, the person may be returned to the community when appropriate for discharge. The RPH staff may decide, for clinical reasons, that a "second opinion" evaluation is needed prior to recommending that the individual return to the community. The court can require that a second opinion evaluation be conducted prior to returning the individual to the community. These evaluations will be conducted by the local Community Forensic Psychiatry Center.

When a court revokes a conditional release commitment, the individual will be admitted with either an IST-U-CJ (R.C. [2945.39](#)) or NGRI (R.C. [2945.40](#)) forensic legal status. The RPH staff must follow the original procedures to return the patient to conditional release status.

Guidelines for Hospitalization due to a Conditional Release Plan Violation. When a person on CR violates one or more of the conditions of the CR plan, the community treatment provider must notify the Forensic Monitor. The monitor should immediately inform the trial court of the violation and the risk issues. If the monitor is unavailable, the community mental health treatment provider should notify the court.

A determination should be made as to the imminence and level of violence risk that the person's noncompliance poses to the community. The judge may consult with the Forensic Monitor,

community treatment provider, or other knowledgeable individuals in order to determine the most appropriate course of action.

After gathering information and reviewing the risks involved, the judge may issue a *capias*, have the person detained in jail, and then issue a Temporary Order of Detention to allow for the person to be evaluated. The judge also has the option to issue a Temporary Order of Detention requiring that the individual be hospitalized for an evaluation. In most cases, the judge will consult with the Forensic Monitor to determine the best placement for the individual, which could include jail, the RPH, or continued placement in the community depending upon the seriousness of the violation.

Pursuant to section [2945.402 \(C\)](#) of the Revised Code, within ten court days after the person's detention or arrest, the court shall conduct a hearing to determine whether the conditional release should be modified or terminated. The court may order a continuance of the ten-court-day period for no longer than ten days for good cause shown or for any period on motion of the individual. The Forensic Monitor should attend these hearings. If the court decides to continue the conditional release commitment, the individual may return to the community, or if appropriate, may be committed to a psychiatric facility for short-term stabilization treatment. In most cases, the judge will consider the status of the individual, the conditional release violation, and input from the Forensic Monitor.

The court may decide to revoke the conditional release commitment, and commit the individual to an ODMH RPH. The individual will be admitted with either an IST-U-CJ (R.C. [2945.39](#)) or NGRI (R.C. [2945.40](#)) forensic legal status. When a court revokes a conditional release commitment, the RPH staff must follow the original procedures to return the patient to conditional release status. When the individual is hospitalized, the Forensic Monitor shall continue to monitor the individual's progress. When a person on CR is hospitalized in an RPH the Forensic Monitor will work with the Legal Assurance Administrator (LAA) to coordinate discharge plans. As appropriate, the community treatment provider should continue to have contact with the individual during hospitalization.

If the court fails to conduct the hearing within the ten court day period and does not order a continuance, the individual will be restored to the prior conditional release status.

The court may, at any time, alter the original conditional release plan and the conditional release order. The Forensic Monitor shall inform the community provider of any changes in the individual's status or conditional release plan.

Conditional Release Commitment Directly from the Court to the Community

When a person has been found Not Guilty by Reason of Insanity, pursuant to section [2945.40](#) of the Revised Code, or a defendant has been committed as Incompetent to Stand Trial—Unrestorable—Under Criminal Court Jurisdiction, pursuant to section [2945.39\(A\)](#) of the Revised Code, the court shall hold a hearing to determine if the person is a mentally ill person subject to hospitalization by court order. At the hearing pursuant to section [2945.39\(D\)\(1\)](#) or [2945.40\(A\)](#) of the Revised Code, the court may consider all relevant information, including, but not limited to, any relevant psychiatric, psychological, or medical testimony or reports, the acts constituting the offense, and any history of the person or defendant that is relevant to the person's or defendant's ability to conform to the law.

If the trial court determines that the person is a mentally ill person subject to hospitalization, the court may commit the person or defendant to the Ohio Department of Mental Health, a facility operated by the Department of Developmental Disabilities, or another medical or psychiatric facility, as appropriate. In determining the place and nature of the commitment, the court shall order the least restrictive commitment alternative available that is consistent with public safety and the welfare of the person or defendant. In weighing these factors, the court shall give preference to protecting public safety.

The trial court may elect to commit the person or defendant to conditional release in the community when it has been determined that this is the least restrictive commitment alternative. In these situations, the court will typically commit the individual to an ADAMHS/CMH board or a community mental health treatment agency. When this occurs, a Nonsecured Status (“second opinion”) evaluation from a Community Forensic Psychiatric Center is *not* required. The court may choose to order an evaluation of the individual, but this would not be considered a “second opinion” evaluation as described in section [2945.401\(D\)\(1\)\(b\)](#) of the Revised Code.

When an individual is placed on a conditional release commitment directly from the court, the Forensic Monitor is responsible to monitor the individual and provide reports from the treating agency to the court after the initial six months of treatment and every two years after the initial report is made. Each report shall indicate whether the person continues to be a mentally ill person subject to hospitalization by court order. For defendants committed as IST-U-CJ, the report shall also contain a statement as to whether the defendant remains incompetent to stand trial (R.C. [2945.401\(C\)](#)).

In cases where the individual is directly committed to conditional release in the community, the following guidelines should be followed to ensure that public safety and the welfare of the individual are considered and addressed:

1. If the Community Forensic Psychiatry Center examiner conducts an evaluation of a person found NGRI in order to offer an opinion concerning the least restrictive setting pursuant to section [2945.40\(A\)](#) of the Revised Code and recommends that the community is the least restrictive setting, the examiner will also recommend that the court notify the local Forensic Monitor to ensure that the required monitoring activities occur. If the court’s decision is to commit the individual directly to conditional release in the community, such notification would allow the Forensic Monitor to become involved at the time that the commitment is made and to perform the required monitoring duties as soon as possible.
2. If the court decides to retain jurisdiction over a defendant found IST-U-CJ pursuant to section [2945.39\(D\)](#) of the Revised Code, and if the court decides, at that point, that the least restrictive treatment alternative is the community (so that the person is immediately placed on conditional release), the court should notify the local Forensic Monitor of its decision. This notification would allow the Forensic Monitor to become involved and provide the required monitoring duties as soon as possible.
3. Forensic Monitors shall proactively maintain communication with the courts in the areas that they serve. This will facilitate the court’s early notification of the monitor in cases where the court directly commits an individual to conditional release. Depending upon the preferences

of the court, the monitor may maintain communication with bailiffs, other court administrative personnel, or the judges themselves.

4. Whenever a person is found NGRI or IST-U-CJ, the prosecutor is required to send to the place of commitment all reports of the defendant's current mental condition and additional information including a transcript of the hearing, copies of relevant police reports, and copies of any prior arrest and conviction records that pertain to the person and that the prosecutor possesses, unless the release of the information would interfere with the effective prosecution of any person or would create substantial risk of harm to any person (R.C. [2945.39\[D\]\[2\]](#), [2945.40\[G\]](#)). If the person is committed to an ADAMHS/CMH board, then the prosecutor will send the above information to the board. If the person is committed to a community agency, program or facility, then the prosecutor will send the above information to that agency, program or facility, which will then send the information to the ADAMHS/CMH board of the committing county. When the Forensic Monitor receives copies of the above documents, the Forensic Monitor will send this information to the place of commitment, the Board, and the treating agency, if they have not already received this information.
5. The Forensic Monitor shall work in coordination with the designated mental health treatment agency and the individual to identify risk factors, to develop the conditional release plan, and the treatment plan.
6. As in any other conditional release commitment, the court may set any conditions on the release with respect to treatment, evaluation, counseling, or control of the individual that the court considers necessary to protect the public safety and the welfare of the individual. The trial court may revoke an individual's conditional release and order placement in a more restrictive environment at any time the conditions of the release have not been satisfied. The revocation shall be in accordance with section [2945.402](#) of the Revised Code. The procedures described above under "Hospitalization of Persons on Conditional Release" should be followed.
7. The Forensic Monitor shall ensure that the community mental health treatment providers follow the Guidelines for Community Risk Assessment of Persons on Conditional Release. These guidelines recommend the completion of the initial risk assessment within thirty (30) days after the person has been on conditional release. After the initial risk assessment, an update should be completed at least every 180 days, or at any time when an incident occurs that raises concern about whether the person poses an increased risk of violence. (Please see [Appendix M](#), Risk Assessment Guidelines for People on Conditional Release).

Community Linkage Program

The Community Linkage Program is operated by the Office of Forensic Services (OFS) of the Ohio Department of Mental Health (ODMH). This program operates in accordance with the guiding principles and identified priorities of ODMH.

ODMH developed the program in coordination with the Ohio Department of Rehabilitation and Correction (ODRC) as a response to an identified need. The primary purpose of the Community Linkage Program is the improvement of continuity of mental health care for offenders entering and leaving the prison system.

The Community Linkage Program, under the supervision of the Chief of the Office of Forensic Services, consists of a Community Linkage Manager (CLM) and Community Linkage Social Workers (CLSWs). The duties of the CLM include supervision of the CLSWs, collaboration and liaison with the area Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards or Community Mental Health (CMH) Boards and other stakeholders on linkage procedures, and program coordination with the prisons, jails, psychiatric hospitals, and community mental health and substance abuse service providers within their areas. Each ODRC prison has an assigned/designated CLSW who is responsible for providing linkage services to that prison's mental health population.

Vision Statement

The ODMH Community Linkage Program strives to aid all offenders with severe and persistent mental illness in their mental health recovery and stability by providing high quality, holistic and timely continuity of care services upon entering and leaving prison.

Mission Statement

The Community Linkage Program will facilitate continuity of mental health care for persons entering or leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. This will promote reduced recidivism rates for persons with mental illness who are leaving the prison system and reduce the number of persons incarcerated due to their illness.

Program Goals

1. Provide continuity of mental health care for offenders entering or leaving an ODRC prison who are identified with serious and persistent mental illness (SPMI).
2. Reduce recidivism of persons with mental illness who are involved in the criminal justice system.
3. Reduce de-compensation rates of released offenders to increase chances at recovery and successful reintegration.
4. Build and strengthen information sharing and alliances across systems.
5. Facilitate problem solving between the corrections and mental health systems and offenders related to accessing community mental health services.
6. Enhance public safety by arranging post-release mental health services, recovery supports and benefits.

For access to the full Community Linkage Manual, please refer to the following website:
<http://mentalhealth.ohio.gov/assets/forensic-services/community-linkage-manual.pdf>

Mental Health Diversion Alternatives

Recently, there has been a growing awareness of problems arising from an increase in the number of persons with mental illness involved in the criminal justice system. Although four of the five most common offenses with which persons with mental illness are charged are not violent crimes, persons with mental illness are over-represented in jails and prisons. The increasing number of persons with mental illness in the criminal justice system is commonly referred to as the criminalization of the mentally ill. Judges and others in the criminal justice system well recognize the “revolving door syndrome” in which people with histories of mental illness are repeatedly arrested for committing minor and nonviolent offenses. Where appropriate, these people are better treated in the mental health system. While ODMH is working on all fronts to improve the quality of care given to persons with mental illnesses, the Department realizes the importance of identifying specific evidence-based practices for the forensic population.

ODMH is especially concerned about the interface between the mental health and criminal justice systems. In order to improve outcomes for persons with mental illness, the mental health and criminal justice systems must be better aligned and collaboration between systems at all levels must occur. The direction for improved services at the interface of corrections and mental health is clear: diversion into supervised treatment, appropriate evidence-based services for those incarcerated, and care and follow-up available upon release. Resources and collaboration are key components for diversion to occur.

Diversion places people with mental illnesses in supervised community treatment instead of jails. Diversion alternatives can occur at various intercept points of the criminal justice process. However, diversion at the earliest possible point of a mentally ill person’s contact with the criminal justice system is preferred. There are many counties in Ohio implementing various jail diversion programs including but not limited to crisis intervention teams (CIT), specialized mental health and veteran courts/dockets, probation/mental health teams, mental health/court liaisons, linkage upon release, and specialized community support teams.

Diversion to treatment may occur at any stage in the criminal justice system. The following is a comprehensive model of the components of a mental health jail diversion program.

Essential Treatment Components Needed to Support Diversion

Before a diversion from the criminal justice system can be made, there must be a supportive treatment service system in place and available to the diversion staff. Particular attention should be paid to the issues of medication compliance, substance abuse and possibly an outpatient commitment mechanism to assist in diverting persons with mental illnesses from the criminal justice system. Various types of diversion are listed below:

Pre-booking

This diversion happens at the earliest point of contact with law enforcement. An example would be Crisis Intervention Teams (CIT) that provide diversion at the pre-booking/arrest stage.

Booking Stage

Diversion can occur within the first 24 hours following arrest. Identification of jailed offenders with a mental health history may prompt a diversion plan, when appropriate. Programs may utilize screening and assessment tools and a court liaison to work with the court to divert.

Pre-Trial

Competency to Stand Trial is an issue that can be raised pre-trial that may divert a person with mental illness to the treatment system. During the pre-trial stage, persons with mental illness may be diverted to a mental health court (specialized docket). Prosecutors may agree to drop the charges for persons with mental illness in the pre-trial stage provided the person agrees to participate in treatment as a part of a diversion plan.

Trial

An NGRI (Not Guilty by Reason of Insanity) finding due to mental illness will lead to mental health treatment in either an inpatient or outpatient setting.

Post-Conviction

After an individual is convicted, there are still diversion alternatives available such as:

- Delaying sentencing and mandating a treatment regimen which, if completed successfully, could reduce the sentence.
- Probation with intensive mental health treatment could be offered to the mentally ill offender instead of jail time.
- Judicial Release, early release to a treatment program.
- In-jail mental health assessment, screening, treatment, and linkage.
- Community linkage from state prisons (ODMH Community Linkage Program).

The Ohio Department of Mental Health is able to provide technical assistance and consultation if a community is interested in establishing diversion programs at the local level. In addition, the Supreme Court of Ohio has a specialized docket section that is dedicated to assisting communities, law enforcement, judges and others in establishing specialized dockets including mental health courts, substance abuse courts and veteran courts. The Ohio Department of Mental Health is able to assist interested parties in contacting The Supreme Court of Ohio for more information. There are numerous other resources available. If interested, please contact the Office of Forensic Services (614-466-1099) for assistance.

GLOSSARY

Absent with Leave (AWL) - A situation that occurs when permission has been granted for an individual's authorized leave and is within the guidelines of a hospital, institution or agency.

Absent Without Leave (AWOL) - A situation that occurs when an individual's departure or elopement from a hospital, institution or agency has occurred without required consent or approval.

ADAMHS Board - Alcohol, Drug Addiction and Mental Health Services Board is the body constituted according to section [340.02](#) of the Revised Code, has its duties described in section [340.03](#), and has the same meaning as a Community Mental Health Board for the purpose of this Manual.

Adult Parole Authority (APA) - An entity that may be responsible, by Court order, for an inmate who is released from prison before an expired sentence. There are usually conditions present that the individual agrees to abide by in order for the release to occur, and the individual is under the supervision of a parole officer (PO) after leaving the prison.

Affidavit - A written statement taken or made under an oath before an officer of the Court, or a notary public, or other person who has been duly authorized to so act.

Arrest - The step in the Criminal Court process wherein the defendant is formally charged with an offense.

Capias - A warrant for arrest.

Case Management Services - Services provided to assist a person in gaining access to needed medical, social, educational and other supports that are essential to meeting basic human needs. Major components of the service include coordinating assessments, treatment planning, crisis assistance, referral and linkage to community resources, advocacy, and monitoring of adjustment and service needs. Case Management is generally provided by a case manager or a team of mental health service providers. The involvement of the client, family member(s) and/or significant others in the treatment process is encouraged. Also referred to as Community Psychiatric Supportive Treatment Service.

CBCF - Community Based Correctional Facility. A secure facility used to house offenders eligible for a local prison diversionary program. Many of these facilities provide specialized treatment programs and are usually operated by one large county or several small counties.

CCO - The Chief Clinical Officer is the Medical Director of an ODMH RPH.

CCOE - Coordinating Center of Excellence is an organization established by ODMH to promote the adoption of evidence-based practices in the treatment of persons with mental illness, such as dual diagnosis integrated treatment and crisis intervention teams (law enforcement and mental health).

CEO - The Chief Executive Officer is the Executive Director of an ODMH RPH.

Certificate of Parole - A certificate that is issued by the Adult Parole Authority (APA) to an institution that allows them to release an inmate on shock parole or parole. The certificate will be inclusive of the following information: the parolee's name and institutional number; parole on or after date (i.e., date set by the parole board, on which an inmate can be released; the inmate can leave on that date or any time after, providing the inmate has an approved parole placement); release date(s); reporting instructions; and special conditions.

CMH Board - see ADAMHS Board.

Community Forensic Monitor - A person, agency or entity designated by the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or Community Mental Health (CMH) Board to monitor Not Guilty by Reason of Insanity (NGRI) acquittees and Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction (IST-U-CJ) defendants on conditional release commitment (R.C. 2945.402). See R.C. [5119.57](#).

Community Forensic Psychiatry Center - A community agency that provides forensic evaluation services for the local Court system and the ODMH RPHs. Each community forensic center is certified as a mental health agency to provide forensic evaluation services. (Also called Community Forensic Psychiatric Centers as described in section [5122-32-01](#) of the Ohio Administrative Code.)

Community Mental Health Agency/Provider - Any agency, program, or facility with which an Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board or Community Mental Health (CMH) Board contracts to provide services listed in section [340.09](#) of the Revised Code

Competency to Stand Trial - A defendant is presumed to be competent to stand trial unless it is proved by a preponderance of the evidence that because of the defendant's present mental condition, the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense (R.C. [2945.37](#)).

Competency Restoration Services - Treatment services provided to an individual who has been found by the Court to be incompetent to stand trial. The treatment is focused on restoring the individual's competency to stand trial. Competency Restoration Services can be provided on an inpatient or outpatient basis.

Conditional Release - A commitment status that has been ordered by the Criminal Court when the Court determines that the community is the least restrictive placement alternative that is appropriate for the individual. Persons who are committed as Not Guilty by Reason of Insanity or Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction are subject to placement on Conditional Release Commitment, pursuant to section [2945.402\(A\)](#) of the Revised Code.

Conditional Release Plan - A plan that is developed with input from the community treatment agency representative, the Community Forensic Monitor, the Criminal Court, the defendant or individual, and RPH staff, as applicable. The conditional release plan indicates the conditions that the defendant or person agrees to abide by while on conditional release commitment. The court may set any conditions of the release with respect to the treatment, evaluation, counseling, or control of the defendant or person that the court considers necessary to protect public safety and the welfare of the defendant or person.

Convey - To provide escort and transportation, usually by law enforcement personnel.

County of Committing Court - The county where the criminal charges were filed.

County of Legal Residence - The county of the person's usual residence (R.C. [5122.01\[S\]](#)).

County of Service Provision - A county other than the county of the committing court or the county of legal residence where a person may be receiving mental health services. Generally, this would be applicable to persons on conditional release commitment.

Court Day/Working Day - Means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday.

Court Order/Journal Entry - A written declaration by the court that orders something to occur or memorializes a court event that has taken place. Generally, a journal entry includes a case number, the defendant's name, date of hearing, charge, degree of the offense, statute number, the parties involved, and the finding of the Court.

Criminal Courts - The Ohio Constitution provides for the establishment of Common Pleas Courts in each of Ohio's counties. Common Pleas Courts have jurisdiction in felony cases. The Ohio Revised Code gives "inferior" Courts such as Municipal, County, or Mayor's Courts jurisdiction in misdemeanor cases.

CSN - Community Support Network programs, previously known as State Operated Services (SOS). CSN staff provide community mental health services in various settings in the community and contract with an ADAMHS or CMH Board to provide these services.

Defendant - A person accused of having committed a crime.

Detainer/Holder - A request from law enforcement to detain/hold an individual until the individual can be returned to the custody of law enforcement.

Examiner - Pursuant to section [2945.37\(A\)\(2\)](#) of the Revised Code, one of the following: A psychiatrist or a licensed clinical psychologist who satisfies the criteria of division (I)(1) of section 5122.01 of the Revised Code or is employed by a certified forensic center designated by the Department of Mental Health to conduct examinations or evaluations; or for purposes of a separate mental retardation evaluation that is ordered by a court pursuant to division (H) of section 2945.371 of the Revised Code, a psychologist designated by the director of the Department of Developmental Disabilities pursuant to that section to conduct that separate mental retardation evaluation.

Ex-Post Facto - A legal term that means after the fact. This usually indicates that a law cannot change and inflict a greater punishment or apply different criteria other than the law required at the time of the commission of the offense.

Felony - A major offense for which the Revised Code provides a punishment of six months or greater of incarceration.

Forensic Evaluation Service - An evaluation conducted by a qualified professional that results in a written expert opinion of an individual who has been referred by a Criminal Court, Domestic Relations Court, Juvenile Court, Adult Parole Authority, or other agency of the Criminal Justice System. Forensic Evaluation Service includes all related case consultation and expert testimony. These services provide assistance to the Court, RPHs, community mental health agencies and other providers in addressing mental health legal issues. See Ohio Administrative Code [5122-29-07](#).

Forensic Monitor - See Community Forensic Monitor.

Forensic Review Team - (FRT) An Ohio Department of Mental Health RPH team appointed by the Chief Clinical Officer (CCO)/Designee. The team shall include a psychiatrist or psychologist who has clinical expertise and forensic experience and is not involved in the treatment of the patient being evaluated, and may include the RPH Legal Assurance Administrator/designee. Other staff may be assigned to the FRT as determined by the CCO. Refer to MF-04, Movement Policy, for more details concerning the FRT.

Grand Jury - A jury of people who convene in private to evaluate accusations against persons charged with a crime and determine whether an indictment is warranted.

Hearing - A procedure wherein evidence is taken for the purpose of determining an issue of fact and reaching a decision on the basis of that evidence.

High Profile Patient - This term includes any patient who has been charged with or convicted of one of the following crimes or who falls under the following criterion: criminal homicide (aggravated murder or murder); felony sexual offenses (rape); other felony offenses against public officials or law enforcement officers; or the patient's offense has generated extensive media coverage.

Incident - Any event that poses a danger to the health and safety of persons served and/or staff of the facility, institution or agency, and is not consistent with routine care.

Indictment - A formal written accusation charging one or more persons with the commission of a crime. It is presented by a grand jury to the Court when the jury has found, after examining the evidence presented, that there is a valid case for prosecution.

Indigent (Person) - An individual who has been determined (following an investigation by the Court, its designated authority, or the Ohio Department of Mental Health Reimbursement Services) to be a financially destitute or needy person. For legal matters, one who is entitled to the appointment of legal counsel at public expense.

Inmate - A person confined in a prison, community-based correctional facility, jail or workhouse.

Inpatient Service - Refers to residence and treatment provided in a psychiatric facility or Regional Psychiatric Hospital, or a unit licensed by ODMH in accordance with section [5119.20](#) of the Revised Code.

Insanity - 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 sections [2901.01\(A\)\(14\)](#) and [2901.05](#) of the

Revised Code, that at the time of the commission of the offense, that the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts. (R.C. [2945.371\[G\]\[4\]](#)).

IST-R - Designates a legal status used commonly to indicate a defendant who has been found by a court to be Incompetent to Stand Trial—Restorable and committed pursuant to section [2945.38\(B\)](#) of the Revised Code as Incompetent to Stand Trial for Restoration Treatment.

IST-U - Designates a legal status used commonly to indicate a defendant who has been found to be Incompetent to Stand Trial—Unrestorable, committed pursuant to section [2945.38\(H\)\(4\)](#) of the Ohio Revised Code as Incompetent to Stand Trial—Unrestorable, and is under Probate Court Jurisdiction.

IST-U-CJ - Designates a legal status used commonly to indicate a defendant who has been committed pursuant to Section [2945.39\(A\)\(2\)](#) of the Revised Code as Incompetent to Stand Trial—Unrestorable—Criminal Court Jurisdiction, and remains under the jurisdiction of the Criminal Court.

Jail - A building for the confinement of people who are awaiting trial or who have been convicted of misdemeanor or lesser level felony offenses.

Journal Entry – (See Court Order)

Judgment - The determination of a Court upon a matter submitted to it.

Jurisdiction - The right of a Court to hear a case, which is limited by geographical boundaries, the nature of the case, and statutory authority.

Least Restrictive Environment - In determining placement alternatives, the Court shall consider the extent to which the person is a danger to the person and to others, the need for security, and the type of crime involved and shall order the least restrictive alternative available that is consistent with public safety and treatment goals. In weighing these factors, the Court shall give preference to protecting public safety for forensic patients.

Legal Assurance Administrator (LAA) - Each Ohio Department of Mental Health (ODMH) RPH has a staff person designated as Legal Assurance Administrator. The LAA acts as a representative of the RPH when working with the Courts, attorneys, ODMH and other mental health and criminal justice agencies regarding forensic patients. The LAA frequently provides the link and coordination between the RPH, the community and the court system for forensic patients.

Licensed Clinical Psychologist – Refer to Section [5122.01\(I\)](#) of the Ohio Revised Code.

Maximum Security Psychiatric Facility - The most restrictive care setting for patients who are committed to an Ohio Department of Mental Health hospital. The maximum-security unit is operated in Columbus, Ohio at Twin Valley Behavioral Healthcare (TVBH) and is called the Timothy B. Moritz Forensic Unit. This unit provides treatment services to persons who represent a severe risk of harm to others and to the public.

Mental Illness - A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life (R.C. [5122.01\[A\]](#)).

Mental Retardation - A condition reflecting below average general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period (R.C. [5123.01\[N\]](#)).

Mentally Ill Person Subject to Hospitalization by Court Order - See Section [5122.01\(B\)](#) of the Revised Code.

Misdemeanor - A minor offense for which the statutes provide a lesser punishment than for a felony; the penalty is usually a fine or imprisonment for six months or less in a jail or workhouse.

Mitigation - In order to establish a frame of reference in a case before a Court, the Court may request the probation department to review the case, criminal record, social history, and the defendant's present condition in order to prepare a presentence report. A psychiatrist or psychologist may be requested to develop a report for the Court. These probation and mental health reports may assist the judge in selecting a less punitive disposition of the case by providing insight into the motives and other conditions that contributed to the criminal behavior.

NGRI - Designates a legal status, and relates to individuals found Not Guilty by Reason of Insanity pursuant to Section [2945.40](#) of the Revised Code.

Nolle Prosequi - A declaration that the plaintiff in a civil case or the prosecutor in a criminal case will drop prosecution of all or part of a suit or indictment.

Nonsecured Status - Any unsupervised, off-grounds movement or trial visit from an RPH or any conditional release, that is granted to a person who is found incompetent to stand trial and is committed pursuant to Section [2945.39](#) of the Revised Code, or to a person who is found not guilty by reason of insanity and is committed pursuant to Section [2945.40](#) of the Revised Code.

ODADAS - Ohio Department of Alcohol and Drug Addiction Services.

ODMH - Ohio Department of Mental Health.

DODD - Ohio Department of Developmental Disabilities

OFS - Office of Forensic Services of the Ohio Department of Mental Health.

ORC - Ohio Revised Code, has the same meaning as RC (Revised Code).

Petition - A formal written request for a certain thing to be done; also an application to a Court or judge, stating the facts and circumstances relied upon as a cause for judicial action, and containing a formal request for relief. The petitioner is the person who presents the formal written request.

Plea Bargain - A negotiated settlement that involves a guilty plea to a reduced charge, and involves a negotiated settlement of a criminal charge or deferred prosecution.

Pre-Hospitalization Screening Service - The assessment of a person's need for psychiatric hospitalization in order to assure that less restrictive alternative placements are considered and used when appropriate. This service may be provided in the person's natural environment or any setting where the need for such an intervention occurs.

Probable Cause - Interpreted as reasonable cause, the matter of having more evidence for than against. A reasonable ground for the belief in the existence of facts warranting the proceedings. The existence of an apparent state of facts whereupon reasonable inquiry it appears the accused has committed the act with which he or she is charged.

Probable Cause Hearing - Process or procedural step in a legal matter in which the judge or magistrate decides whether a complaint should be issued or a person should be bound over to a grand jury on a showing of probable cause.

Probate Court - Probate Court is a division of the Common Pleas Courts that exercises jurisdiction over probating wills, administration of estates, guardianships, and declaring persons mentally ill and in need of hospitalization.

Probation - The suspension of sentence of a person convicted but not yet imprisoned, on condition of continued good behavior and regular reporting to a probation officer. A supervised period of monitoring in the community in lieu of incarceration.

Prosecutor - Refers to a prosecuting attorney or a city director of law, village solicitor, or similar chief legal officer of a municipal corporation who has the authority to prosecute a criminal case that is before the Court.

Psychiatrist - Refer to Section [5122.01\(E\)](#) of the Revised Code.

RC - Revised Code, has the same meaning as Ohio Revised Code (ORC).

Recognizance - A person charged with a crime may be released by the Court based on that person's word that the person will reappear when ordered. The Court may require certain conditions of an individual who is released on this type of bond.

Respondent - The person who answers a Petition.

Risk Assessment - An assessment that is completed on individuals for the purpose of making short-term clinical estimates of violent behavior and identifying static and dynamic risk factors to be addressed in an aggression prevention treatment plan.

RPH - Regional Psychiatric Hospital means the six state hospitals operated by ODMH. A broad array of mental health services are provided in acute and long-term environments and through Community Support Networks (CSNs).

Second Opinion Evaluation - An evaluation that is conducted by the Community Forensic Psychiatry Center prior to the Court granting the first nonsecured level of movement for a

defendant who is committed pursuant to R.C. [2945.39\(A\)](#), or a person committed pursuant to R.C. [2945.40](#) to an Ohio Department of Mental Health RPH. A second opinion evaluation occurs after the internal RPH review process and is initiated by the Chief Clinical Officer's recommendation to the Court for an increase in movement level.

Subpoena - A document commanding the attendance of a person in court.

Temporary Order of Detention - An order issued by the court which temporarily detains an individual so that the court can gather additional information and make a decision.

Torts - Intentional or negligent acts directly causing damage to an individual for which civil action can be brought.

Trial Docket Entry - An official entry with respect to a trial through which the Court "speaks."

Trial Visit - A level of movement for a hospitalized patient that refers to an unsupervised stay in the community with an expectation of return to the RPH at designated times.

Unsupervised, off grounds movement - Refers to a patient level of movement which includes off-grounds privileges that are unsupervised and that have an expectation of return to the RPH on a daily basis.

Vacate - To render void, or set aside.

Warrant - A writ or order of a Court authorizing an officer to make an arrest, seizure, or search, or perform some other designated act.

Workhouse - A security institution managed by a county or municipality where misdemeanor offenders are confined and required to work.

Writ of Habeas Corpus - A document to bring the petitioner before a Court to inquire into the legality of the petitioner's confinement.

Appendix A

ODMH Regional Psychiatric Hospitals

Appalachian Behavioral Healthcare (ABH)

100 Hospital Drive, Athens, OH 45701

740-594-5000; toll free: 800-372-8862

[Hospital web page](#)

Heartland Behavioral Healthcare (HBH)

3000 Erie St. South, Massillon, OH 44646

330-833-3135; toll free: 800-783-9301

[Hospital web page](#)

Northcoast Behavioral Healthcare (NBH)

1756 Sagamore Rd., Northfield, OH 44067

330-467-7131; toll free: 800-557-5512

[Hospital web page](#)

Northwest Ohio Psychiatric Hospital (NOPH)

930 Detroit Ave., Toledo, OH 43614

419-381-1881; toll free: 877-970-4325

[Hospital web page](#)

Summit Behavioral Healthcare (SBH)

1101 Summit Rd., Cincinnati, OH 45237

513-948-3600; toll free: 888-636-4724

[Hospital web page](#)

Twin Valley Behavioral Healthcare (TVBH)

2200 West Broad St., Columbus, OH 43223

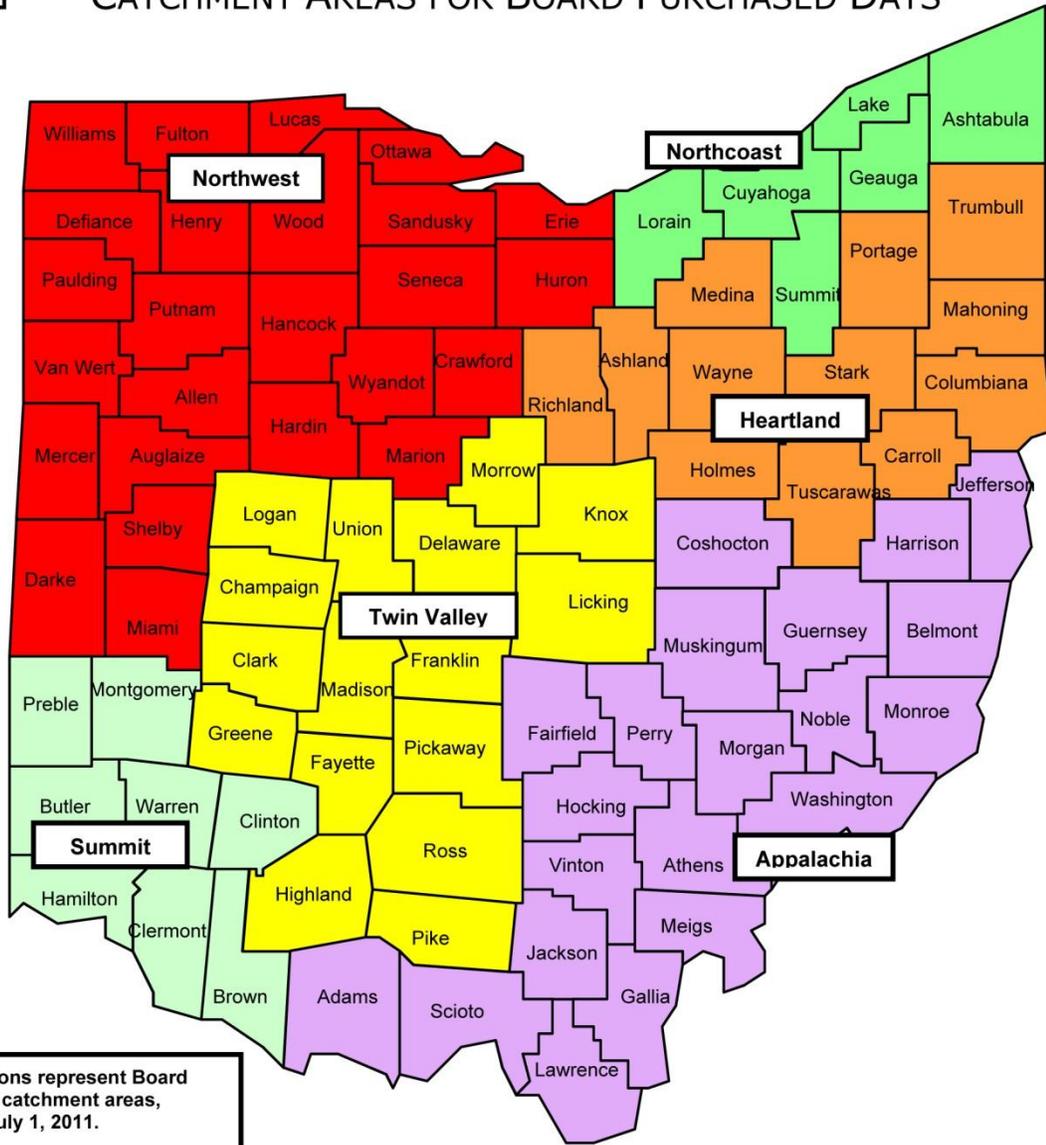
614-752-0333; toll free: 877-301-8824

[Hospital web page](#)

Appendix B

Effective
7/1/2011

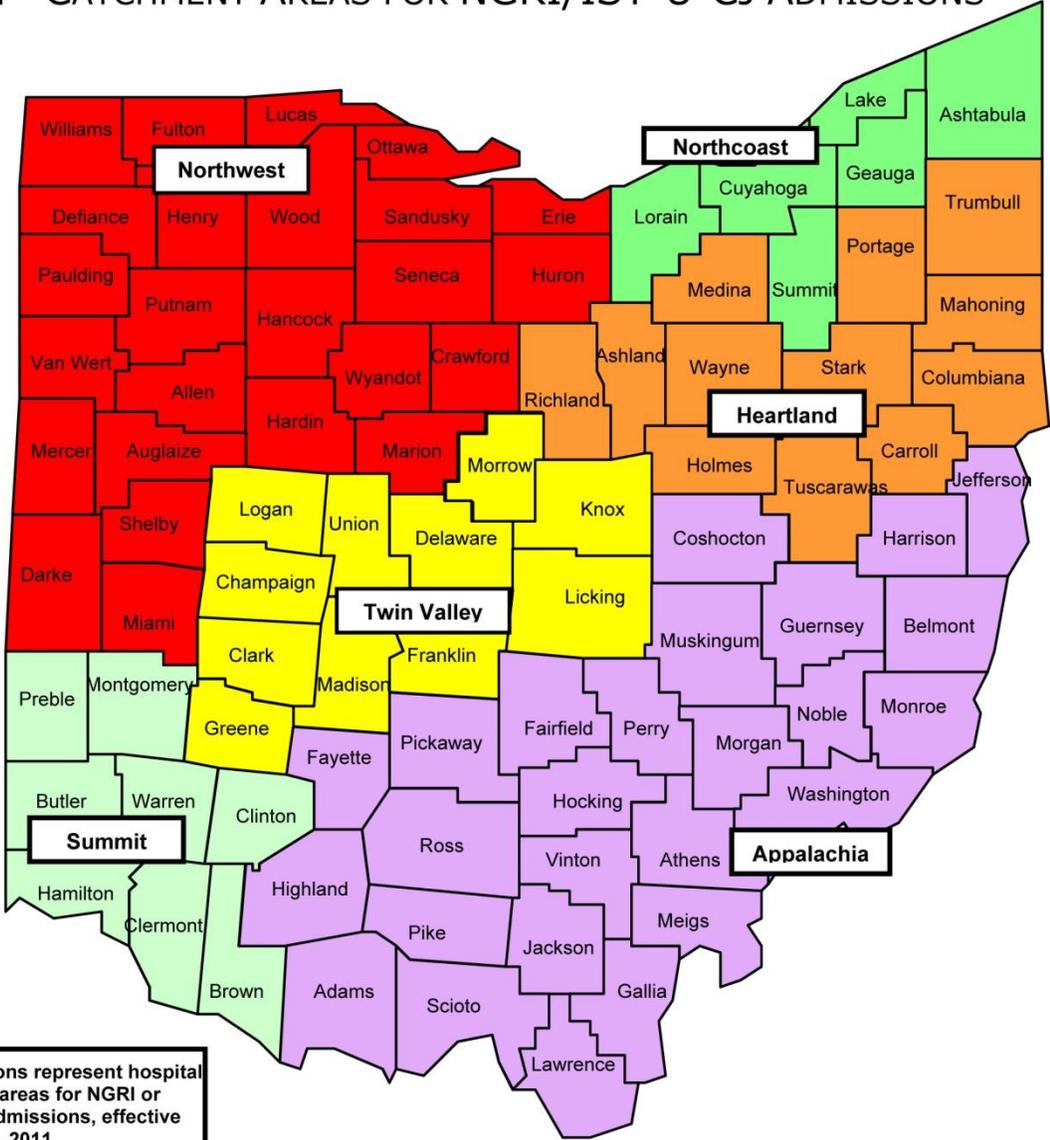
ODMH REGIONAL PSYCHIATRIC HOSPITAL
CATCHMENT AREAS FOR BOARD PURCHASED DAYS



Note: Regions represent Board admission catchment areas, effective July 1, 2011.

Effective
10/15/2011

ODMH REGIONAL PSYCHIATRIC HOSPITAL CATCHMENT AREAS FOR NGRI/IST-U-CJ ADMISSIONS



Note: Regions represent hospital catchment areas for NGRI or IST-U-CJ admissions, effective October 15, 2011.

Appendix C

OHIO DEPARTMENT OF MENTAL HEALTH

Document Number: MF-03

Type of Document: Policy

**Authority Source: ORC Sections 2945.38; 2945.39
2945.40; 5119.01 and 5119.07**

Document Title: Risk Assessment Policy

Applicability Statement: Regional Psychiatric Hospitals

"Exceptions" if Applicable: None

Effective Date: 10-20-2009

**Replaces: 10-9-1998 (Reviewed 10-13-2-00;
12-1-2002; 4-28-2006; 8-12-2008)**

Directed To: Regional Psychiatric Hospitals

Distributed By: Office of Forensic Services

Risk Assessment Policy

A. Purpose

This policy establishes guidelines for clinical risk assessments of patients that carry a specific forensic legal status as defined below. The risk assessment shall be an important part of the clinical record guiding such activities as:

1. Movement
2. Violence prevention planning, and,
3. Conditional release or discharge

B. Application

This policy shall apply to each regional psychiatric hospital (RPH).

C. Definitions

1. "Forensic legal status" for the purpose of this policy means:
 - a. ORC section 2945.38 (H)(4), Incompetent to Stand Trial - Unrestorable (IST-U); probate court jurisdiction;
 - b. ORC section 2945.39 (A)(2), Incompetent to Stand Trial - Unrestorable (IST-U-CJ); criminal court jurisdiction;
 - c. ORC section 2945.40, Not Guilty by Reason of Insanity (NGRI); or,

- d. ORC section 2967.22 and Chapter 5122., Mentally Ill Probationer or Parolee.
 - “Movement Level 1” means On Unit, Restricted
 - “Movement Level 2” means Off Residential Unit, Supervised
 - “Movement Level 3” means On Grounds, Unsupervised
 - “Movement Level 4” means Off Grounds, Supervised
 - “Movement Level 5” means Off Grounds, Unsupervised

See ODMH policy MF-04, “Movement of Patients Committed Under a Forensic Status”, for complete definitions of movement levels.

- 2. “High risk patient” means a patient admitted to the RPH who represents an elevated risk of escape, violence, other dangerousness, or who is a high profile case.

D. Policy

Each RPH chief clinical officer (CCO) shall be responsible for the development of RPH policies and procedures for the implementation of this policy.

E. Procedure

- 1. Clinical risk assessment of a patient is the responsibility of the treatment team. The clinical risk assessment instrument specified by the Ohio Department of Mental Health (DMH-FORS-002) shall be completed by licensed medical or mental health professionals on the treatment team. The treatment team may be assisted by the Legal Assurance Administrator (LAA) and other such specialists as available.
- 2. Initial risk assessments shall be completed on all patients admitted under an above-defined forensic legal status (both felony and first degree misdemeanor charges).
 - The initial assessment shall consist of a thorough review of the current individual and family history, mental status and present condition of the patient; and a review of past mental health, juvenile justice, adult criminal, military, court, forensic center, and corrections records. Documented reasonable efforts shall be made to acquire the above information.
- 4. The initial assessment shall be completed within thirty days of admission. Additional information received after completion of the initial assessment shall be appended to the initial risk assessment.
- 5. The Forensic Review Team (FRT) shall be appointed by the CCO/designee and consist of two or more clinical staff with expertise in forensic work.
 - a. The FRT must include:
 - i. Psychiatrist or psychologist with clinical expertise and forensic experience who is not involved in the treatment of the patient being evaluated for movement; and
 - ii. At least one other independently licensed clinician with forensic experience whom the CCO assigns. If the LAA is an independently licensed mental health professional, he or she may serve in this capacity.
 - b. The FRT may also include a non-clinician LAA, or LAA designee.

6. The FRT shall review the initial and updated risk assessments in consideration of:
 - a. Movement of forensic patients charged with aggravated murder, murder, and Felony 1 or Felony 2 offenses prior to granting Level 2 movement outside of the residential unit in which they reside; and
 - b. Prior to granting Level 3 movement or higher to all forensic patients.
- F. Updated risk assessments shall be performed for patients on the following occasions:
 1. For forensic patients charged with aggravated murder, murder, and Felony 1 or Felony 2 offenses, prior to a request for Level 2 movement (Off Residential Unit, Supervised).
 2. For all forensic patients charged with a Misdemeanor 1 or higher offense, prior to requesting Level 3 movement (On Grounds, Unsupervised) or higher.
 3. When a transfer from maximum security to civil mental hospital unit is considered.
 4. Patients charged with a Felony 2 or higher offense will have a risk assessment update at least every six months.
 5. At least annually for patients charged with a Felony 3, Felony 4, Felony 5, or Misdemeanor 1 offense on Levels 3, 4, and 5 movements, if no update has been performed for one year.
- G. The risk assessment instruments (initial and update) shall be placed in the medical record. The initial and at least the last two updates (if completed) shall not be culled from the current record.
- H. Risk assessment factors of special relevance shall be identified and specifically addressed in the treatment plan.
- I. The clinical risk assessment instrument form and this procedure may be used for any patient regardless of legal status. Such use is encouraged as an effective method of assessing high risk patients.
- J. Risk assessment findings, along with the treating clinicians' and teams' assessments, are used in treatment planning activities and reports, including court reports.

Appendix D

OHIO DEPARTMENT OF MENTAL HEALTH

Document Number: MF-04
Type of Document: Policy
Authority Source: ORC Sections 5119.01 and 5119.07
Document Title: Movement of Patients Committed Under a Forensic Status
Applicability Statement: ODMH Regional Psychiatric Hospitals
“Exceptions” if Applicable: None
Effective Date: 10-20-2009
Replaces: MH-P-FS-06 (10-13-1995); ODMH: 20, (7-1-1997); and 98-33, Movement of Patients Committed Under a Forensic Status; 1-29-99; (Reviewed 10-13-2000; 11-8-2004; 4-28-2006; 8-12-2008)
Directed To: ODMH Regional Psychiatric Hospitals
Distributed By: Office of Forensic Services

**Movement of Patients
Committed Under a Forensic Status**

A. Purpose:

This policy contains procedures for determining and recommending movement levels based on a patient’s clinical condition and hospital/community safety for those patients committed under a forensic legal status, and/or patients who have been identified as being at high risk for violence. The movement level system provides for the safety of patients and staff, and fulfills ODMH's responsibilities regarding custody, while providing appropriate treatment.

B. Applicability:

“Forensic status” for the purpose of this policy includes people who have serious mental illness, have some involvement with the criminal justice system and fall under one of the following categories:

1. Jail transfers and police holds;
2. Competency/sanity evaluation – ORC section 2945.371(G)(3) and (4);
3. Incompetent to stand trial - Restoration Tx - ORC section 2945.38(B);
4. Incompetent to stand trial - Unrestorable – ORC section 2945.38(H)(4);
5. Maintain competency - ORC section 2945.38(A);

6. Incompetent to stand trial - Unrestorable - criminal court jurisdiction - ORC section 2945.39(A);
7. Not guilty by reason of insanity – ORC section 2945.40;
8. Mentally ill probationer or parolee – ORC section 2967.22 and Chapter 5122.;
9. Continuing evaluation and treatment of restorability to competency – ORC section 2945.38(B)(1).

C. Definitions and policy:

1. Levels of movement - definitions

a. Level 1: On Residential Unit, Restricted.

The patient shall not be permitted out of a locked residential area except under at least one-to-one escort (also known as one-to-one supervision) to another locked area. A locked area is a unit, building, or other area from which a person cannot leave without someone unlocking a door, gate, etc.

b. Level 2: Off Residential Unit, Supervised.

The patient shall be permitted access to all areas of the regional psychiatric hospital (RPH) according to hospital policy except those restricted for all patients, but shall not be permitted off grounds. Supervision means a patient is in the same space (room or area) with a staff member and the patient shall be within view of the staff member at all times.

c. Level 3: On Grounds, Unsupervised.

The patient shall be permitted access to specified off-unit areas of the RPH (within or outside of the perimeter of the hospital building) according to hospital policy except those restricted for all patients, but shall not be permitted off grounds.

d. Level 4: Off Grounds, Supervised.

Supervised by RPH or community agency staff; the patient shall be permitted to leave the grounds with RPH or community agency staff supervision and shall remain under staff supervision until his/her return. Supervision means a patient is in the same space (room or area) with a staff member and the patient shall be within view of the staff member at all times.

e. Level 5: Off Grounds, Unsupervised.

The patient shall be permitted to leave the grounds without supervision for a specified period of time, with an expectation of return to the RPH on a daily basis.

f. Trial visit - Unsupervised community contact with an expectation of return to the RPH at designated times.

g. Conditional release - A commitment status under which a person receives treatment in the community for a period of time not to exceed the maximum term of imprisonment that the person could have received if convicted of the most serious offense charged.

2. "High risk patient" means a patient admitted to the RPH who represents an elevated risk of escape, violence, other dangerousness, or who is a high profile case.

3. Medical Movement

a. Emergency Medical Movement

Pursuant to ORC section 2945.38(E), the RPH chief clinical officer (CCO) or designee may grant a defendant committed under this section movement to a medical facility for emergency medical treatment. Recognizing ODMH'S responsibilities regarding custody, movement under this section should be made with appropriate supervision to ensure the safety of the defendant, staff, and community during the emergency medical situation. The CCO/designee shall notify the court within twenty-four hours of the defendant's movement to the medical facility.

b. Non-emergency Medical Movement

Pursuant to ORC section 2945.38(E), the court may grant a defendant supervised off-grounds movement to obtain medical treatment or specialized habilitation treatment services, if the CCO informs the court that this treatment cannot be provided at the RPH.

4. Levels of movement allowed by forensic status:

a. Jail transfers/police holds – ORC section 5122.10;

i. Definition: Persons transferred from law enforcement custody on an emergency basis for stabilization.

ii. Movement permitted: Level 1 – On Unit, Restricted.

iii. Discharge: When the CCO or designee determines that the patient is no longer mentally ill subject to hospitalization, s/he shall notify the Legal Assurance Administrator (LAA) or designee. The LAA/designee will coordinate the discharge with the sheriff or other law enforcement agency having a hold on the patient. The LAA/designee will verbally notify the sheriff or other law enforcement agency of the patient's readiness for discharge. If there is no response, the LAA/designee shall send notification by certified mail, return receipt requested. The sheriff or other law enforcement agency shall take custody of the patient. The patient shall not be released to anyone except the sheriff or other law enforcement agency unless the sheriff or other law enforcement agency indicates to the hospital in writing that s/he no longer wishes to hold the patient.

b. Competency/sanity evaluation – ORC section 2945.371(G)(3) and (G)(4);

i. Definition: A person committed to a RPH by the court to determine the person's competence to stand trial or sanity at the time of the offense.

ii. Movement permitted: Level 1 – On Unit, Restricted

iii. Discharge: The CCO/designee shall notify the LAA/designee who will coordinate the patient's release with the court when the examination has been completed. The patient shall not be released except to be returned to court.

c. Incompetent to stand trial – Restorable (IST-R) – ORC section 2945.38(B);

- i. Definition: A person found by the court to be incompetent to stand trial due to mental illness or mental retardation and committed for competency restoration treatment within time limits prescribed by law.
 - ii. Movement Permitted:
 - Level 1 – On Unit, Restricted;
 - Level 2 – Off Residential Unit Supervised;
 - The patient may not apply for voluntary admission.
 - iii. Discharge:
 - a. The CCO/designee shall notify the LAA/designee when s/he determines that: 1) The defendant is competent to stand trial; 2) The defendant is unrestorable to competency; or 3) The defendant's maximum period for commitment for restoration is about to expire.
 - b. The LAA/designee shall send a report to the court prior to the expiration date of the maximum time allowed by law for restoration. The report shall be sent to the court fourteen days prior to the expiration date for a felony charge and ten days prior for a misdemeanor charge.
 - c. The LAA/designee shall coordinate the patient's discharge. The patient shall not be released except to be returned to court.
- d. Maintain Competency – ORC section 2945.38(A);
- i. Definition: A defendant who has been found competent to stand trial by the court, most of the time is receiving psychotropic drugs or other medication, and the court has authorized continued commitment at the RPH in order to maintain the defendant's competence to stand trial.
 - ii. Movement Permitted:
 - Level 1 - On Unit, Restricted
 - Level 2 - Off Residential Unit, Supervised
 - iii. Discharge: The patient shall not be released except to be returned to court.
- e. Incompetent to Stand Trial - Unrestorable (IST-U) – ORC section 2945.38(H)(4);
- i. Definition: A person who has been found by the criminal court to be incompetent to stand trial, unrestorable and subsequently found to be a mentally ill person subject to hospitalization by the probate court.
 - ii. Movement Permitted:
 - Level 1 – On Unit, Restricted;
 - Level 2 – Off Residential Unit, Supervised;
 - Level 3 – On Grounds, Unsupervised;
 - Level 4 – Off Grounds, Supervised;
 - Level 5 – Off Grounds Unsupervised, or Trial Visit.
 - a. The prosecutor shall be notified, in writing, prior to Level 5 movement or discharge being granted.
 - b. Upon receiving this notice, the prosecutor shall either re-indict or promptly

notify the court of intention not to prosecute charges.

- c. Prompt notification is required to the prosecutor, in writing, of the patient's change to voluntary status, and shall include the date the patient was committed or admitted on a voluntary status.
- iii. Discharge: The patient shall be discharged when the CCO/designee or the probate court determines that s/he is no longer in need of hospitalization by court order or no longer requires hospital level care. The LAA/designee shall notify the prosecutor by certified mail, return receipt requested, at least ten working days prior to discharge (unless the discharge is granted by the probate court) and shall state in the notice the date on which the patient will be discharged.
- f. Incompetent to Stand Trial – Unrestorable Under Criminal Court Jurisdiction (IST-U-CJ) – ORC section 2945.39(A)(2);
 - i. Definition: A person who has been charged with murder or a violent felony offense of the first or second degree and has been found by the criminal court to be incompetent to stand trial unrestorable; and upon motion of the prosecutor or the court has been found by clear and convincing evidence at a hearing to have committed the charged offense and is a mentally ill individual subject to hospitalization by court order under the continuing jurisdiction of the criminal court.
 - ii. Movement Permitted:
 - Level 1 – On Unit, Restricted;
 - Level 2 – Off Residential Unit, Supervised;
 - Level 3 – On Grounds, Unsupervised;
 - Requires court approval. Discretionary hearing at the request of the court or prosecutor.

 - Level 4 – Off Grounds, Supervised;
 - Requires court approval. Discretionary hearing at the request of the court or prosecutor.

 - Level 5 – Off Grounds, Unsupervised, Trial Visit; or Conditional Release (Non-secured status);
 - Requires second opinion from forensic center for the first of any non-secured status movement.
 - Requires court approval. Mandatory court hearing.

 - For conditional release, a collaborative plan involving the community mental health agency and the community forensic monitor is required.

 - The patient may not apply for voluntary status.

 - The court shall be notified if, at any time, the person is clinically assessed as competent to stand trial.
 - iii. Discharge: Requires second opinion from the forensic center. Requires court approval. Mandatory court hearing.

The person or hospital may petition the court for discharge if the person no longer is a person subject to hospitalization by court order, as defined in ORC section 5122.01(B).

The maximum time of commitment is the longest sentence which the person could have served if convicted of the most serious charged offense. When the maximum time of commitment occurs, the patient must be discharged or civilly committed.

The LAA/designee shall coordinate all notification and movement with the court, prosecutor, and forensic center.

g. Not Guilty by Reason of Insanity (NGRI) – ORC section 2945.40;

i. Definition: A person found not guilty by reason of insanity who has been found to be a mentally ill individual subject to hospitalization by the criminal court.

ii. Movement Permitted:

Level 1 – On Unit, Restricted;

Level 2 – Off Residential Unit, Supervised;

Level 3 – On Grounds, Unsupervised;

Requires court approval. Discretionary hearing at the request of the court or prosecutor.

Level 4 – Off Grounds, Supervised;

Requires court approval. Discretionary hearing at the request of the court or prosecutor.

Level 5 – Off Grounds, Unsupervised; Trial Visit; or Conditional Release (Non-secured status);

Requires second opinion from forensic center for the first of any non-secured status movement.

Requires court approval. Mandatory court hearing.

For conditional release, a collaborative plan involving the community mental health agency and the community forensic monitor is required.

The patient may not apply for voluntary status.

iii. Discharge:

Requires second opinion from forensic center.

Requires court approval. Mandatory court hearing.

The maximum time of commitment is the longest sentence which the person could have served if convicted of the most serious offense charged. When the maximum time of commitment occurs, the patient must be discharged or civilly committed.

The LAA/designee shall coordinate all notifications and movement with the court, prosecutor and forensic center.

h. Parolee or probationer who is mentally ill; ORC section 2967.22 or Chapter 5122.;

- i. Definition: A person on parole or probation who is considered mentally ill. If the affidavit is filed by a parole or probation officer, the patient is committed pursuant to section 2967.22 ORC. If the affidavit is filed by another person, or the patient signs an application for voluntary admission, the patient is admitted pursuant to ORC Chapter 5122.
- ii. Movement Permitted:
 - Level 1 – On Unit, Restricted
 - Level 2 – Off Residential Unit, Supervised
 - Level 3 – On Grounds, Unsupervised
 - Level 4 – Off Grounds, Supervised
 - Level 5 – Off Grounds, Unsupervised or Trial Visit

The LAA/designee may notify the parole or probation officer, with the patient's consent in writing, prior to granting Level 5 movement. The LAA/designee shall notify the parole or probation officer when the patient is absent without leave (AWOL) if the person is committed pursuant to ORC section 2967.22.

- iii. Discharge: When the CCO/designee determines that the patient is no longer mentally ill subject to hospitalization, the patient shall be discharged. If the patient consents in writing, the LAA/designee shall notify the parole or probation officer of the release.

5. Treatment Team Requirements

- a. The patient's forensic status shall be documented on the treatment plan and may be identified as a focus of treatment on the plan.
- b. Prior to a request for Level 2 movement (Off Residential Unit, Supervised) for forensic patients charged with aggravated murder, murder, and Felony 1 or Felony 2 offenses, the treatment team shall conduct a current risk assessment update; and for all forensic patients charged with a Misdemeanor 1 or higher offense, the treatment team shall conduct a current risk assessment update prior to requesting Level 3 movement (On Grounds, Unsupervised) or higher.
- c. The treatment plan shall include risk management interventions that address the factors of special relevance identified in the risk assessment.

6. Procedure for Movement

- a. No one admitted or returned from AWOL shall be permitted movement from a locked unit until reviewed by the treatment team. A risk assessment update must be completed prior to the granting of Level 3 and above movement. RPHs shall develop policies and procedures regarding who, how, and when the treatment team will review movement after a patient returns from AWOL.
- b. No patient shall be permitted movement without initiation by and approval of the treatment team (see ODMH policy MF-03, "Risk Assessment Policy"). Patient movement to Levels 3, 4, and 5 must be documented in the medical record by the treatment team, and the physician's order must be specific as to location of movement, including: in-building, on-grounds, and off-grounds movement. In-building and on-grounds movement must be consistent with hospital policy in terms of location.

- c. All movements at Level 2 (Off Residential Unit, Supervised) and above, shall be coordinated with the LAA to ensure legal issues are addressed properly.
- d. A Forensic Review Team (FRT) shall review:
 - i. Movement of forensic patients charged with aggravated murder, murder, and Felony 1 or Felony 2 offenses prior to granting Level 2 movement outside of the residential unit in which they reside; and
 - ii. For all forensic patients charged with a Misdemeanor 1 or higher offense, the FRT shall review prior to granting Level 3 movement or above.
- e. Movement of forensic patients charged or convicted of Misdemeanor 2 or lower offenses may be determined by the treatment team without FRT review.
- f. Before Level 2 (Off Residential Unit, Supervised) or above movement is granted, justification for the rationale for increased movement and the parameters of the movement must be documented in the patient's medical record.
- g. Prior to exercising Level 2 or above movement, on a daily basis, a member of the treatment team shall screen patients for any conditions that may preclude movement. Documentation of this screening must be contained in the patient's medical chart.
- h. Movement to highly crowded social and community events such as fairs, fireworks, etc. is restricted to those patients who have approved Level 5 movement (Off Grounds Unsupervised). Patients who have Level 4 movement (Off Grounds Supervised) may be considered for such events if prior to the event:
 - i. Specific justification for the event is documented in the treatment team notes;
 - ii. Approval by the chief clinical officer or designee is documented in the medical record; and
 - iii. Enhanced supervision above and beyond the usual supervision for groups on Level 4 is arranged.
- i. Prior to the implementation of any changes in movement level, the CCO shall review and approve the recommendations of the FRT.

7. Forensic Review Team (FRT)

- a. The FRT shall be appointed by the CCO/designee and consist of two or more clinical staff with expertise in forensic work. The FRT must include:
 - i. Psychiatrist or psychologist with clinical expertise and forensic experience who is not involved in the treatment of the patient being evaluated for movement; and
 - ii. At least one other independently licensed clinician with forensic experience whom the CCO assigns. If the LAA is an independently licensed mental health professional, he or she may serve in this capacity.

- b. Responsibilities of the FRT shall include: reviewing all requests for movement under Procedure for Movement. The FRT shall:
 - i. Review the initial clinical risk assessment and any updates;
 - ii. Conduct a clinical interview with the patient; and
 - iii. Review any other relevant material i.e., clinical records, conduct an interview with treatment team staff, etc.
- c. Approval or denial (by FRT or CCO) of the requested movement shall be communicated in writing to the treatment team within fourteen days. If denied, the FRT shall provide to the patient and treatment team clear expectations regarding the patient's treatment and/or behavior in order to be granted future movement or recommended to the court for future movement. The treatment team shall discuss the results of the review with the patient.
- d. As the patient moves toward non-secured status, the treatment team and/or FRT shall consult with the forensic monitor or community case managers for input.
- e. The patient may appeal a denial of movement at any level as provided in the client's rights grievance procedure. The patient shall be notified of the right to appeal by the treatment team.

D. Monitoring

1. The treatment team shall meet and review the treatment plan, the patient's current approved movement, and compliance with movement at least monthly or when an event or incident occurs which is related to the patient's identified risk factors or one or more of the following factors:
 - a. Positive drug or alcohol screen;
 - b. Deterioration in the patient's mental status or return of overt symptomatology;
 - c. AWOL;
 - d. Violation of hospital rules regarding significant contraband;
 - e. Incidents with family or others in the community while on pass; and/or
 - f. Any threatening or violent behavior.
2. The treatment team shall review all written notes regarding the patient's handling of off grounds movement.
3. Before a patient is granted non-secured movement (Off Grounds, Unsupervised, Trial Visit), the patient shall sign a form entitled "Agreement and Conditions for Unsupervised Leave". Patients who work or visit family on a regularly scheduled basis must sign a form prior to the first visit. The treatment team shall review the form with the patient monthly and the patient shall initial and date the form. Any changes in conditions shall prompt completion and signing of a new form.
4. The form will include a statement of the time and place of the off-grounds activity, including a return time, and any limitation on activities. The patient shall also

consent to drug and alcohol screening if indicated. The patient will also consent to allow staff to interview persons (family, friends, employer) as indicated in section (D)(5)(b) and (5)(c) of this policy.

5. When a patient leaves the grounds:

- a. With supervision from RPH or community agency staff: hospital staff shall interview the patient within twenty-four hours of return and complete a form which contains questions about the patient's reaction to various settings, relationships, etc. This form shall be placed in the medical record.
- b. Without staff supervision: staff shall interview the patient and the family or person with whom the patient visited within twenty-four hours of return and complete documentation, which shall be placed in the medical record, that contains the answers to questions about the patient's reaction to various settings, relationships, etc.
- c. To work on a regular basis: staff shall interview the work supervisor at least once per month and complete documentation, which shall be placed in the medical record that contains the answers to questions about the patient's reaction to the work setting, relationships with others in the work setting, etc.

E. Documentation

1. The results of each review of movement (approval or denial) shall be documented on a specially developed form which shall be placed in the patient's medical record in the progress notes and legal section.
2. The medical record shall be marked on the outer cover in such a way as to indicate the person is committed under a forensic status.
3. A mechanism shall be in place to ensure staff are aware of each patient's legal status and approved movement.

F. Clinical Risk Assessment

1. Risks assessments shall be completed in accordance with ODMH policy MF-03, "Risk Assessment Policy".
2. Each RPH may require additional, more restrictive policies which should be followed as applicable.

G. Training

1. All CCOs, Recovery Rights Advocates (RRAs), LAAs, and other FRT members shall be trained to implement this policy.
2. CCOs, LAAs, and FRT members will train their RPH's treatment team staff to implement this policy.
3. Each RPH shall schedule regular meetings to discuss forensic issues. All levels of staff shall be involved in these meetings consistent with the philosophy of quality improvement.

4. At least annually, in-service training shall be offered to staff regarding forensic issues.

H. Procedures:

1. Each RPH shall develop internal policies and procedures which are consistent with this ODMH policy and are approved by the CEO and CCO.
2. On an ongoing basis, each RPH shall review the quality of performance regarding the forensic movement process defined in this policy.
3. Each RPH CCO/designee shall conduct an annual review of the RPH's policy and procedures related to treatment and movement of forensic patients, implementation of policy and procedures, and continuous quality improvement efforts and training regarding forensic issues. If problems or concerns arise with the implementation of the policy, the CCO shall consult with the chief of the Office of Forensic Services.

Appendix E

Length of Time Available for Restoration to Competency:

[ORC 2945.38 \(C\)](#):

No defendant shall be required to undergo treatment, including any continuing evaluation and treatment, under 2945.38 (B)(1) for longer than whichever of the following periods is applicable:

- (1) **One year**, if the most serious offense with which the defendant is charged is one of the following offenses:
 - (a) Aggravated murder, murder, or an offense of violence for which a sentence of death or life imprisonment may be imposed;
 - (b) An offense of violence that is a felony of the first or second degree;
 - (c) A conspiracy to commit, an attempt to commit, or complicity in the commission of an offense described in division (C)(1)(a) or (b) of this section if the conspiracy, attempt, or complicity is a felony of the first or second degree.
- (2) **Six months**, if the most serious offense with which the defendant is charged is a felony other than a felony described in division (C)(1) of this section;
- (3) **Sixty days**, if the most serious offense with which the defendant is charged is a misdemeanor of the first or second degree;
- (4) **Thirty days**, if the most serious offense with which the defendant is charged is a misdemeanor of the third or fourth degree, a minor misdemeanor, or an unclassified misdemeanor.

Appendix F

EXAMPLE

NOTIFICATION TO COURT AND COMMUNITY FORENSIC PSYCHIATRY CENTER
REQUESTING SECOND OPINION EVALUATION

Date

Dear Judge _____;

Pursuant to Section 2945.401 (D) of the Ohio Revised Code, and as CCO of _____ Regional Psychiatric Hospital (RPH), I am in agreement with the treatment team, and the Forensic Review Team in recommending to the Court that _____ be granted a (unsupervised off grounds, conditional release, trial visit, discharge, or termination of the commitment). _____ is currently committed to _____ RPH pursuant to Section 2945.40 or 2945.39 of the O.R.C.

A copy of this recommendation, along with the attached court report, and a conditional release plan (when the request is for conditional release) is being sent to the _____ Community Forensic Center as a notification that a second opinion evaluation is being requested for _____. The second opinion evaluation is to be completed by the Forensic Center examiner within thirty (30) days. A copy of the evaluation will be sent to your Court and _____ RPH.

After the report has been completed, the RPH will again assess our original request and determine if we plan to withdraw, proceed with, or modify and proceed with, our recommendation. We will notify you of our intentions when we receive the second opinion evaluation from the Community Forensic Center.

At that time, if we are in agreement to proceed with or modify and proceed with our request, we understand that a hearing date will be set. Please contact _____, the Legal Assurance Administrator at () if you have questions or require additional information regarding this case.

Sincerely,

Chief Clinical Officer/Designee

cc. Director, (Community Forensic Center)
Prosecuting Attorney
Defense Counsel

Appendix G

Examination and Report Format for Competency to Stand Trial and Not Guilty by Reason of Insanity Evaluations (in ODMH RPHs)

Competency Evaluation and Not Guilty by Reason of Insanity
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I. Identifying Data/Reason for Examination:

- A. Identifying Data
Name, Age (DOB), Marital Status of Defendant
- B. Criminal Charges against Defendant
Number of charges, Names of Charges, Degree of Legal Severity (level of felony or misdemeanor), Specifications
- C. Referral Source
County of Referral, Name and Title of Referring Individual (Judge, etc.), Court Case Number
- D. Referral Question
Ohio Revised Code Statute and Explanation
ORC 2945.371(G)(3) Competency To Stand Trial
ORC 2945.371(G)(4) Mental Condition at the Time of the Alleged Offense (for NGRI)

II. Examination Procedure

- A. Date (s) of Examination
- B. Place of Examination (i.e., jail, hospital, forensic center) Indicate public or private surroundings
- C. Length of time of examination
- D. Who was present during the examination (nurses, student, etc.)
- E. Explanation of limits of confidentiality, Defendant's understanding or response

III. Collateral Information Reviewed - List Sources such as:

- A. Police Reports
- B. Indictment
- C. Witness Statements
- D. Statement of Defendant to Police
- E. Prior Criminal Record
- F. Autopsy Report
- G. School Records
- H. Medical, Psychiatric and Mental Health records - past and present
 - 1. Interviews with significant others (family, friends, etc.), who were interviewed and how long
- J. Contacts with Defense Attorney and Prosecutor

IV. Past History (if relevant) of the Defendant including:

- A. Family medical or mental illness history, unusual ethnic, religious or cultural beliefs in family in relationship to the law
- B. Child and Adolescent Development (Brief)
- C. Education, grades completed, special education, grade failures
- D. Military Duty
- E. Employment
- F. Past Criminality - juvenile and adult
- G. Substance Abuse
- H. Medical
- I. Psychiatric Hospitalization
- J. Mental Health Treatment

<u>Competency to Stand Trial</u>	<u>Not Guilty by Reason of Insanity</u>
<p>V. Current Mental Status Examination</p> <ul style="list-style-type: none"> A. Appearance, speech, mannerisms, odd behavior B. Thought process disorder, inappropriate affect, thought content disorder (delusions, obsessions, etc.) C. Hallucinations D. Depression or mania symptoms E. Dissociative disorder or amnesic syndrome F. Orientation, attention, concentration, memory, ability to abstract and intelligence level G. Current medical problems and significant medication H. Current state of substance abuse, if any I. Ability to relate to examiner; to listen and respond with relevant information 	<p>V. Defendant's account of the alleged offense(s) including thoughts, feelings and behavior</p> <p>Attempt to recreate the day of the alleged offense(s) including thoughts, feelings and behavior</p> <p>Where was the defendant? Whom did he or she see? What did he or she see? What did he or she do? What was he or she thinking?</p>

<p><u>Competency to Stand Trial</u></p> <p>VI. Specific Competency Areas</p> <p>A. Understand his or her legal situation and charges against him/her</p> <p>B. Understand the legal defenses available</p> <p>C. Understand the dispositions, and penalties possible</p> <p>D. To appraise the roles of the defense attorney, judge, jury, and witness(es)</p> <p>E. To relate collaboratively and communicate relevantly with the defense attorney</p> <p>F. To disclose pertinent facts about the alleged offense to his or her attorney. <u>Incriminating information is not to be included in the report</u>, but state whether or not the defendant was able to clearly and rationally describe his/her thinking at the time of the offense.</p> <p>G. To comprehend instructions and make decisions after receiving advice</p> <p>H. To follow testimony for contradictions and errors</p> <p>I. To testify relevantly</p> <p>J. To tolerate stress at the trial</p> <p>K. To refrain from irrational or unmanageable behavior at the trial</p> <p>VII. Brief description of current inpatient behavior and functioning;</p> <p>A. Summary of relevant records, excluding any incriminating information; and</p> <p>B. Any relevant psychological testing summary if performed</p> <p>VIII. Current DSM Diagnosis Axis I, II How was the diagnosis reached; alternative diagnoses</p> <p>IX. Clinical Discussion How do the clinical factors (symptoms, behavior) affect competency issues?</p>	<p><u>Not Guilty by Reason of Insanity</u></p> <p>VI. Mental State at the time of the offense(s)</p> <p>A. Current appearance, speech, mannerisms, odd behavior, thought process disorder, inappropriate affect, and level of intelligence</p> <p>B. At the time of the offense(s):</p> <ol style="list-style-type: none"> 1. Thought content disorder (delusions, obsessions, etc.) 2. Hallucinations 3. Depression or mania symptoms 4. Dissociative disorder or amnesic syndrome 5. Memory and orientation at that time 6. Medical problems at that time 7. Significant medication at that time 8. Substance use at that time <p>VII. Summary of relevant records;</p> <p>A. Indicate any substantial discrepancy from defendant's account of alleged offense, and;</p> <p>B. Relevant psychological testing summary of mental state at time of alleged offense(s) if performed</p> <p>VIII. DSM Diagnosis - at the time of the offense(s), Axis I, II How was the diagnosis reached; alternative diagnoses</p> <p>IX. Clinical Discussion</p>
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<p><u>Competency to Stand Trial</u></p> <p>X. Competency Opinion</p> <p>A. State an opinion as to whether or not the defendant is clinically capable of understanding the nature and objective of the proceedings against him/her <u>and</u> whether or not the defendant is capable of assisting in his/her defense (the legal definition of competency in Ohio) If competent, state any psychiatric measures needed to maintain competency (i.e. medication, continued hospitalization)</p> <p>B. If not competent, whether the defendant is presently mentally ill or mentally retarded; and if in the examiner’s opinion the person is mentally retarded, whether the person appears to be a mentally retarded person subject to institutionalization by court order (i.e., moderately mentally retarded).</p> <p>C. If not competent and mentally ill or mildly mentally retarded, the likelihood that the defendant will be able to be restored to competency within a one year period of time if given a course of appropriate treatment.</p> <p>D. If not competent, and mentally ill or mildly mentally retarded, and likely to be restored in a one year period of time with appropriate treatment, the examiner’s recommendation as to the least restrictive treatment alternative, consistent with the defendant’s treatment needs for restoration to competency and with the safety of the community. Consider suicidal, assaultive or escape potential in making this recommendation. <u>No conclusory statement is required by law using the word “competent” and this word is generally best left for the determination by the judge.</u></p> <p>XIII. Sign and date the report, examiner’s full name, degree and description of profession (e.g. Mary Q. Smith, Ph.D. Psychologist)</p>	<p><u>Not Guilty by Reason of Insanity</u></p> <p>X. NGRI Opinion</p> <p>A. State an opinion as to whether or not the defendant, at the time of each offense charged, as a result of severe mental disease (reversible mental illness) or mental defect (irreversible mental illness or mental retardation) did not know the wrongfulness of his/her acts charged. <u>Do not use the term insanity</u></p> <p>B. Explain why the diagnosis you have made (DSM) does or does not represent a severe mental disease or mental defect.</p> <p>C. Explain factors which led you to the conclusion that any severe mental disease or mental defect present at the time of the alleged offense(s) caused an inability to know the wrongfulness of the acts for which she/he had been criminally charged.</p> <p>XIII. Sign and date the report, examiner’s full name, degree and description of profession (e.g. Mary Q. Smith, Ph.D., Psychologist)</p>
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General Guidelines

1. Limit report to data relevant to requested legal conclusions. Omit embarrassing material unless relevant to the conclusion.
2. Separate pertinent information into subsections: Family history, mental status, forensic opinion, etc.
3. Avoid using technical terms and jargon as much as possible; if unavoidable, explain terms.
4. State facts objectively, avoid pejorative terms.
5. Do not include gratuitous information regarding issues not requested.
6. Prepare separate reports for competency and NGRI if both requested.
7. All opinions must be given to a reasonable degree of medical or psychiatric or psychological or scientific certainty defined as a probability of 51% or greater certainty in Ohio.
8. If an opinion cannot be reached within this level of certainty, simply indicate this in the report.

Appendix H

Ohio Department of Mental Health

DOCUMENT NUMBER: I-02
TYPE OF DOCUMENT: Policy
AUTHORITY SOURCE: Ohio Revised Code Section 5122.20
DOCUMENT TITLE: Transfer Policy within ODMH Regional Psychiatric Hospitals
APPLICABILITY STATEMENT: ODMH Regional Psychiatric Hospitals
EXCEPTIONS IF APPLICABLE: None
EFFECTIVE DATE: 6-8-2010
REPLACES: ODMH-09, 11-1-1995; 98-21; I-02 (Reviewed 4/16/01; 5-8-2007)
DIRECTED TO: ODMH Hospitals
DISTRIBUTED BY: Division of Hospital Services

Transfer Policy within ODMH Regional Psychiatric Hospitals

A. Purpose:

1. The purpose of this policy is to provide procedures for the planned and orderly transfer of civil and forensic patients between ODMH operated regional psychiatric hospitals (RPHs) to assure that consultation occurs between RPHs and community mental health boards in the transfer of patients; and to ensure planned and orderly transfer of patients between maximum security units and civil units, RPH to RPH, including proper "hand-off" communication (as defined in The Joint Commission National Patient Safety Goals).
2. This policy shall also address the procedures for transferring patients to and from maximum security units.

B. Definitions:

1. "Civil hospital unit" means the least restrictive setting for individuals requiring inpatient psychiatric care. This would include a locked civil unit which has the ability to treat and house patients requiring close observation, assessment, and/or competency evaluation for forensic patients. A locked civil unit can also be utilized as a step-down unit from the maximum security unit, or treatment area for jail transfers.
2. "Deputy Director" (for the purpose of this policy only) refers to the Hospital Services Deputy Director, unless otherwise specifically noted.
3. "Designated RPH" means the RPH designated by ODMH to serve the county from which a person was committed or admitted, or the RPH from which a person was transferred to a maximum security unit.
4. "Emergency transfer" means a transfer that occurs when there is a documented immediate need to transfer a patient to a maximum security unit from another ODMH RPH prior to receiving court approval.
5. "High-profile patient" includes any patient who has been charged with or convicted of any of

the following crimes, and/or falls into the criteria listed: criminal homicide (aggravated murder or murder); felony sexual offenses (rape or felonious sexual penetration); other felony offenses against public officials or law enforcement officers; and/or the patient/offense has generated extensive media coverage.

6. "Maximum security unit" means the most restrictive care setting (locked with security staff) for patients committed to Twin Valley Behavioral Healthcare (TVBH) at the Timothy B. Moritz Forensic Unit by Ohio's criminal justice system or probate courts, or referred from other state RPHs operated by ODMH.
7. "Out of service area transfer" means the transfer of a patient from a maximum security unit to a RPH other than the RPH from which the patient was transferred. In the case of a patient who was placed in a maximum security unit directly from court, an out of service area transfer is a transfer to a RPH other than the one designated to serve the county from which the person was committed. The Deputy Director designates out of service area-RPHs in consultation with the ODMH Medical Director.
8. "Out of service area transfer record" means a record kept by the Deputy Director's office which indicates how many patients have been transferred from maximum security units to RPHs other than those designated to serve the counties from which persons were committed.
9. "Receiving RPH" means the ODMH RPH receiving a patient from another ODMH RPH.
10. "Referring RPH" means the ODMH RPH initiating a transfer to another ODMH RPH.

C. Authority:

Section 5122.20 of the Ohio Revised Code (ORC) authorizes the Director of the Department of Mental Health or his/her designee to transfer an involuntary patient, or a consenting voluntary patient from one public hospital to another, or to a hospital, community mental health agency or other facility offering treatment or other services for mental illness, if the ODMH Medical Director determines that it would be consistent with the medical needs of the patient. This policy shall focus on the procedures for transfers between ODMH-operated RPHs. All other patient transfers among facilities referenced in ORC section 5122.20 shall be considered as admissions/discharges. These transfers shall not occur without the consent of the involved facilities or the ODMH Medical Director and Deputy Director. Patients shall have their rights and the transfer procedures explained to them prior to any transfer by the RPH Client Rights Specialist or a designee appointed by the CEO.

D. County of Residence:

1. All transfers among ODMH RPHs as detailed in this policy do not affect county of residence under ORC section 5122.01(S). A change in county of residence status under ORC section 5122.01(S) does not automatically authorize or otherwise cause a transfer to occur. For example, when the patient's legal status changes from ORC section 2945.38(B) - Incompetent to Stand Trial - Restoration Treatment (IST-R) to ORC section 2945.38(H)(4) Incompetent to Stand Trial - Unrestorable (IST-U), many times the county where the charges were filed (for IST-R) is not the person's original county of residence (for IST-U).
2. However, RPHs must notify the new county of residence that the change of residence has occurred and that the person remains in that particular RPH.

E. Reasons for Transfer:

Generally, a transfer may occur for one of the following reasons:

1. The patient's needs can be met more appropriately at another RPH.

2. The transfer will provide improved proximity to family and/or friends.
3. The criminal court has indicated that the patient may be considered for conditional release placement in a community closer to another RPH and the patient agrees with the plan.
4. The patient requires treatment in a more/less restrictive environment, i.e. maximum security unit or civil unit.

F. Transfer Types:

1. Civil hospital unit to civil hospital unit

a. Voluntary/involuntary civil patient transfers:

- i. Voluntary/involuntary (ORC sections 5122.11, 5122.15, 2945.40 and 2945.39(A)) patient transfers between RPH civil hospital units may occur for any of the following reasons:
 1. The patient requests such a transfer because he/she plans to relocate after discharge;
 2. The patient requests a transfer to be closer to family and/or other support systems;
 3. The treatment team determines that the transfer would be in the best interest of the patient for reasons which are documented in the treatment plan and the clinical record.
- ii. The referring RPH treatment team staff shall be responsible to ensure that the patient, as appropriate, has been given information related to: 1) the risks and benefits of the proposed transfer, and 2) the patient's right to refuse the transfer. The treatment team shall also be responsible to assess and document in the clinical record, the patient's capacity to understand his/her choices and to make an informed decision.

b. Preparations for transfer

- i. At the initiation of the transfer discussion, the members of the referring treatment team shall consult with the treatment team/designee(s) of the receiving RPH and make an effort to inform the patient and other interested parties of the proposed transfer and seek input as appropriate. It is encouraged that all concerned parties make every effort to reach consensus regarding the transfer. Transfer requests must be approved by the criminal court for patients committed under ORC sections 2945.40 or 2945.39(A).
- ii. RPH staff shall seriously consider patient preferences for any transfer. If the patient is voluntary, his/her consent for the transfer is required. For involuntary patients, written justification shall be provided in all instances when his/her desires cannot be met regarding the transfer.
- iii. The referring RPH shall notify the receiving RPH, responsible board, and/or designated agency (per ORC section 5122.01(S), county of residence) of the request for the transfer. The referring RPH shall provide the responsible board a written explanation of the rationale for the transfer and shall make every effort to reach consensus with the board regarding the necessity for the transfer within five working days of the notification.

c. Voluntary patient transfers

- i. Probate court permission is mandated (ORC section 5122.20) before a voluntary patient can be transferred without his/her permission. The chief clinical officer (CCO) or designee shall file an affidavit for a hearing under ORC section 5122.11 prior to the transfer.
 - ii. ORC section 5122.20 requires that whenever a consenting voluntary patient is transferred, the patient's permission is required prior to informing his\her legal guardian, parents, spouse, counsel, or nearest known relative.
- d. Involuntary patient transfers
- i. In accordance with ORC section 5122.20, whenever an involuntary patient is transferred, written notice shall be given to his/her legal guardian, parents, spouse, and counsel, or if none is known, to his/her nearest known relative or friend.
 - ii. Before an involuntary patient may be transferred, the CCO/designee shall file a motion with the court requesting an amended order of placement issued under ORC sections 5122.15, 2945.40 or 2945.39A. At the patient's request, the court shall hold a hearing on the motion, at which time the patient has the same rights as at a full hearing pursuant to ORC sections 5122.15(A) or 2945.401.
- e. Transfer process
- i. Once agreement has been reached regarding the transfer by the two RPHs and the patient and the amended placement order has been received, then the referring RPH shall provide current, pertinent patient information as requested by the receiving RPH. The two RPHs shall arrange for a mutually agreed upon transfer time and date, with the referring RPH transporting the patient. The responsible board shall be notified of the transfer time and date by the receiving RPH.
 - ii. Under no circumstances shall any patient be transferred until continuity of care/"hand off" information is conducted by the respective chief clinical officers and/or attending psychiatrists.
- f. Transfer disputes

If the receiving RPH CCO/designee and CEO or the board objects to the transfer, the following procedures shall be implemented:

- i. The CEOs and CCOs/designees of the involved RPHs shall consult with each other and the responsible boards regarding the transfer.
- ii. If all parties, including the involved boards, do not agree with the decision to transfer, the case shall be referred within ten days of the request by the CCO/designee of the referring hospital to the ODMH Deputy Director and Medical Director or designee for a decision. The referral information shall include medical information, clinical assessments, progress notes, and other current and relevant information. The Deputy Director and Medical Director or designee shall render a decision about the transfer within five working days of the notification.
- iii. If the patient and/or guardian disagree with the transfer decision, the referring RPH's Client Rights Specialist shall provide them with access to the RPH Client Rights and Grievance Process. The Client Rights Specialist shall assist the patient and/or guardian in filing a grievance should this be their decision. Except for Emergency Transfers, a patient whose transfer has been appealed through the grievance process shall not be moved until the grievance is resolved.

2. Transfers from civil hospital units to the maximum security unit:

- a. Transfer procedure (also see Attachment B):
 - i. Criteria for admission/transfer to maximum security unit: a patient is eligible for admission to a maximum security setting after a determination has been made that:
 - 1. Patient is a mentally ill person (has substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or meet the ordinary demands of life) and subject to hospitalization; and either,
 - 2. Reasonable less restrictive treatment interventions/alternatives at the patient's civil hospital setting have been attempted and were not successful, and placement in a maximum security hospital represents the least restrictive setting at this point in time, or;
 - 3. The patient is in need of placement in a maximum security psychiatric setting because there exists a likelihood that the patient, as evidenced by recent and past history of overt acts, will do imminent physical harm to others so that continued placement (in other civil settings) is not feasible to ensure the safety of others. Examples include:
 - i.* The patient has repeatedly demonstrated physical violence in the hospital which overwhelms the response resources of civil hospital staff; or
 - ii.* The patient has demonstrated assaultive behavior causing severe physical harm or with life-threatening potential or intent;
 - iii.* The patient has demonstrated an AWOL risk which is linked to an imminent and foreseeable risk of harm to others in the community.
- b. Voluntary patient transfers:
 - i. If a voluntary patient in a civil RPH setting meets the criteria as identified above and agrees to the transfer, then transfer to a maximum security unit shall be arranged and facilitated immediately to ensure the safety of the person, other patients and staff.
 - ii. When a voluntary patient is to be transferred to a maximum security unit, the clinical record shall contain documentation that verifies the patient was given information regarding the risks and benefits of the transfer. Also, members of the patient's treatment team shall document information in the clinical record which verifies the patient's capacity to make an informed decision.
 - iii. When a patient is voluntary, meets the criteria for admission to a maximum security unit, and does not agree to the transfer to the maximum security unit, the referring RPH must file an affidavit in probate court requesting a hearing under ORC section 5122.11. The respective ADAMH board must also agree with the transfer request.
- c. Involuntary patient transfers – patients with civil legal status: When an involuntary patient, who has been probated under ORC section 5122.15 meets the criteria for admission to a maximum security unit, the RPH shall seek approval from the respective ADAMH board and must file a motion with the court to amend the placement order. The patient must be informed and can request a hearing. Once an amended order of placement is received, the hospital shall effect the transfer within three working days.
- d. Involuntary Patient Transfers - Patients with Forensic Legal Status: When an involuntary patient who has been committed to the RPH by a criminal court, meets the criteria for admission to a maximum security unit, the RPH must file a motion in criminal court

requesting an amended placement order. The patient must be informed and can request a hearing. Once an amended order of placement is received, the RPH shall effect the transfer within three working days.

e. Transfer initiation and approval process:

- i. To begin the process of transfer of a patient from a civil RPH unit to a maximum security unit, the referring RPH CCO/designee shall contact the CCO/designee of the TVBH maximum security unit to discuss the referral and then complete the Civil to Maximum Security Unit Transfer Request/Agreement Form (Attachment A):
 1. Specifically describe the reason(s) for the necessity of transfer to the CCO/designee of the maximum security unit, including:
 - A. The specific symptoms or behaviors needing to be addressed, for example, assaultive/threatening behavior, violent outbursts, etc.
 - B. The clinical interventions previously utilized and the outcomes.
 2. Specifically describe the behavioral criteria desired prior to initiating the patient's return to the civil unit.
 3. The referring CEO must contact the TVBH maximum security unit CEO about patient cases that might involve an unusual amount of resources (in the form of one-to-one observations, outside medical care, etc.). This notification shall include specific information regarding the patient's special needs and any appropriate historical information.
 4. Once agreement has been reached regarding the necessity for transfer and the behavioral criteria needed to be achieved prior to the patient's return to the civil hospital unit, the referring RPH shall provide current, pertinent information as requested by the receiving RPH. Prior to the transfer, the treating psychiatrist will communicate with the accepting TVBH psychiatrist to complete the "hand-off" communication. The two RPHs shall arrange for a mutually agreed upon transfer time and date, with the referring RPH transporting the patient.

ii. Emergency exception:

When clinical or risk management circumstances preclude court notification and authorization prior to transfer, the Deputy Director and Medical Director may authorize transfer to maximum security after consultation and agreement with the ODMH Legal Counsel to the Director. The transferring RPH must file a motion for transfer in the appropriate court on the same day as the transfer, or on the next court day.

f. Transfer dispute:

- i. The CEO and CCO/designee of the RPH where the maximum security unit is located shall agree with the transfer request prior to submission of the request to the appropriate court of jurisdiction, i.e., criminal (IST-R, IST-U-CJ (criminal jurisdiction), or NGRI (Not Guilty by Reason of Insanity)); or probate court (civil jurisdiction (IST-U-CJ) or IST-U).
- ii. If there is disagreement between the CCOs/designees over a transfer, the RPH CEOs shall be involved to resolve the disagreement within one working day of the request for transfer.
- iii. When the RPHs cannot reach agreement over a transfer within three working days, the CCO/designee of the referring RPH shall refer the case to the Deputy Director and

Medical Director or designee for a decision. The referral information including medical information, clinical assessments, progress notes, and other current and relevant information shall be sent to the Deputy Director and the Medical Director at the time of the dispute referral. The Medical Director and Deputy Director shall render a decision about the transfer within three working days of the notification. No request for transfer shall be submitted to the court without internal agreement.

G. Maximum Security Unit to Civil Hospital Unit:

1. Transfer procedures: This section is specific to those patients residing in TVBH's Timothy B. Moritz Forensic Unit who, based on relevant documentation, are determined to no longer need treatment in a maximum security unit.

- a. Preparations for transfer

Patients placed in a maximum security unit shall be returned to the RPH from which they were transferred. If the patient was admitted to a maximum security unit directly from court, the patient shall be transferred to the RPH designated by ODMH to serve the county from which the patient was committed, or by the out of service area transfer process described in (G)(2) of this policy.

- i. In all cases where the patient meets the criteria of a "high-profile" patient, RPHs are required to adhere to paragraph (H) of this policy -"Transfer of a High-Profile Patient".
- ii. A transfer request from a maximum security unit to a civil hospital unit shall include a clinical risk assessment (HCR-20) as required in the ODMH policy MF-03, "Risk Assessment Policy" and other supporting assessments/documentation which shall indicate how the transfer will better meet the needs of the individual. All recommendations for transfer from a maximum security unit to a civil RPH hospital unit must be accompanied by a treatment plan specifically addressing risk assessment factors of significant relevance. The maximum security unit is authorized to initiate transfers after consultation and agreement between CCOs/designees of the referring and receiving hospitals. (See ODMH policy MF-03, "Risk Assessment".)
- iii. The maximum security unit CEO shall notify the receiving RPH CEO about patient cases that might involve an unusual amount of RPH resources (in the form of one-to-one observations, outside medical care, etc.). This notification shall include specific information regarding the patient's special needs and any appropriate historical information.
- iv. The Legal Assurance Administrator (LAA) for the maximum security unit shall ensure that the receiving RPH is given all requested information on the patient prior to the transfer. All recommendations for transfer from a maximum security unit to a civil hospital unit must be accompanied by a clinical risk assessment and treatment team and progress note documentation that justifies the rationale for transfer to a less restrictive setting. Prior to the initiation of the transfer process, the CCO/designee of both RPHs must consult and agree to the transfer.

- b. Transfer process:

- i. Once agreement has been reached with all parties regarding a patient transfer, the proper court proceedings must be followed. The hospital CCO/designee must request an amended order of placement from the criminal court as they have the ultimate authority to approve all transfers of patients committed by criminal court to another hospital. The patient may request a hearing.
- ii. The court's approval is not required for patients committed by the probate court who no longer need a maximum security setting; however, the court must be notified.

- iii. The referring hospital shall ensure that, prior to the transfer that the receiving hospital has all of the required patient documentation. This is to include the information listed above and any other documentation as requested by the receiving hospital. All transfers must include physician to physician "hand-off" communication including the opportunity to ask and respond to patient care questions.
- iv. All transfer disputes must be settled prior to requesting the transfer from the court.
- v. The designated hospital shall not contest the transfer at the court hearing.
- c. Transfer disputes: if the receiving RPH CEO and CCO/designee or the Board objects to the transfer, the following procedures shall be followed:
 - i. The CEO and CCO/designee of the involved RPHs shall consult with each other and the responsible boards regarding the transfer.
 - ii. When the RPHs cannot reach agreement over a transfer within three working days, the CCO/designee of the referring RPH shall refer the case to the ODMH Deputy Director and Medical Director or designee for a decision. The referral information shall include medical information, clinical assessments, progress notes, and other current and relevant information that shall be sent to the Deputy Director and the Medical Director at the time of the dispute referral. The Deputy Director and Medical Director or designee shall render a decision about the transfer within three working days of the notification. No request for transfer shall be submitted to the court without internal agreement.

2. Out of service area transfers

a. Maximum security unit transfers to civil hospital units:

On rare occasions, requests for out of service area transfers may be initiated by maximum security units or designated RPHs for any of the following reasons:

- i. The criminal court judge has indicated that he/she will order that a patient not be placed at the RPH designated by ODMH. The CCO/designee of the maximum security unit in conjunction with the designated RPH staff shall consult with the judge and attempt to resolve the judge's concerns. If efforts to resolve the judge's concerns fail, the staff of the maximum security unit shall request an out of service area transfer.
- ii. The criminal court has indicated that the conditional release of the NGRI or IST-U-CJ patient may be considered within the next year to a community closer to a RPH other than the designated RPH and the patient agrees with the plan.
- iii. The patient's family and/or support systems exist in a county other than the county where the charges were filed and transfer to another RPH would enable the family to visit more frequently.
- iv. When the CCO/designee of the designated RPH determines that a transfer of the patient to a new environment would be in the patient's and RPH's best interest due to circumstances, e.g., a crime was committed at the designated service area RPH.

b. Requests for out of service area transfer:

- i. In cases when a maximum security unit is initiating an out of service area transfer, the CCO/designee of the maximum security unit shall consult and review pertinent documentation with the CCO/designee of the designated RPH. As a part of the formal request for transfer, the CCOs/designees shall make a recommendation to the Deputy

Director regarding an alternative RPH (out of service area) to transfer the patient if a particular RPH might best meet the patient's needs.

- ii. The CCO/designee of the maximum security unit shall make a formal written request to the Deputy Director for an out of service area transfer.
- iii. All formal requests for out of service area transfers shall include the following:
 1. Recommendations regarding placement of the patient and the rationale for the recommendation. The request should include all clinical assessments, a treatment plan which addresses risk assessment factors of significant relevance, treatment notations; and
 2. Evidence of consultation with and approval of the board of the patient's county of residence; and
 3. Evidence of consultation with the patient; and
 4. Impact on the patient if the transfer is made out of the respective board area; and
 5. Any additional information as requested.

c. Out of service area assignment:

1. The Deputy Director in consultation with the ODMH Medical Director shall have the authority to assign a hospital to receive a transfer. The Deputy Director's office shall maintain updated information on all out of service area transfers. All efforts will be made to rotate the out of service area transfers between assigned RPHs. Out of area assignment will be made by the Deputy Director within ten working days of receipt of the formal request.

Rationale for assignment includes:

- i. Location of family, friends, or other support systems.
 - ii. RPH closest to the community where the court is likely to allow the person to be placed on conditional release.
 - iii. Patient's wishes.
 - iv. Other circumstances related to the criminal charges and the RPHs ability to meet patient's needs.
2. Staff at the maximum security unit shall not request an order from the court to transfer the patient until the assignment is made from the office of the Deputy Director, and a reply from the designated RPH is received noting agreement with the transfer.
 3. If a dispute arises following the assignment, the Deputy Director will be notified and will consult with the ODMH Medical Director or designee and consider circumstances and information provided to them.
 4. The Deputy Director or designee shall respond to both RPHs regarding the transfer dispute within five working days of receipt of the dispute information.

H. Transfer of High-Profile Patients: When a high-profile forensic patient is being considered for transfer from a maximum security unit to a less restrictive RPH unit, the following procedures shall be implemented.

1. Prior to the initiation of the CCO/designee discussion involving a potential transfer, the CEO of the potential receiving RPH shall be informed by the CEO of the referring RPH. This will allow for the discussion and development of a plan to manage any unusual circumstances related to increased security, media relations, preparation of staff, etc.
2. When agreement between the CCOs/designees has been reached regarding the transfer and the anticipated time frames, the CEO of the receiving RPH and the court shall be notified by the referring CEO. The ODMH Deputy Director, Medical Director or designee, and the ODMH Communications Director will be notified at this time also.
3. The maximum security unit staff shall submit clinical risk assessment information to the receiving RPH which documents the patient's ability to return to the less restrictive setting. All other information as requested by the receiving RPH shall also be submitted.

I. Utilization Review Process:

A utilization review process will be implemented to monitor the referrals, admissions and movement of patients in and out of the Timothy B. Moritz Maximum Security Unit. The Deputy Director, with consultation from the ODMH Office of Quality Improvement, will develop this process.

INTERNAL ODMH CIVIL TO MAXIMUM SECURITY TRANSFER REQUEST/AGREEMENT FORM			
Name of Requesting CCO/Designee:		Date of Initial Contact Requesting Transfer	
Signature of Requesting CCO/Designee:		Method of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> FAX <input type="checkbox"/> Mail	
Patient Name:		No.:	DOB:
Legal Status:		RPH:	DOA:
Diagnoses:		Prescribed Medications:	% Recent Compliance
Axis I:			
Axis II:			
Axis III:			
Any Pending or Recommended Medical Consults or Specialized Medical Needs? Yes No			
<input type="checkbox"/> Criteria for Admission: Check (<input type="checkbox"/>) One Or More & Detail In The Space Below			
<input type="checkbox"/>	Patient is a mentally ill person (has a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or meet the ordinary demands of life) and subject to hospitalization; AND		
<input type="checkbox"/>	EITHER: Likely to cause imminent harm to others, as evidenced by documented recent and/or past history of such behavior, or by evidence that this is likely to occur, if retained in a less restrictive setting		
Date	Incident Description		
<input type="checkbox"/>	OR Lesser restrictive alternatives must have been explored or attempted and are determined as incapable of preventing the patient from likely causing imminent harm to others. As a result, the patient is assessed to be in need of the external control inherent in a maximum-security psychiatric setting, to prevent the patient from committing such harm.		
The following Alternatives have been tried and failed, or are impractical for the following reasons:			
Alternative	Tried (Dates)	Failed (Y, N)	Impractical Because:
Emergency Medication			
Forced Medication			

The following Alternatives have been tried and failed, or are impractical for the following reasons:			
Alternative	Tried (Dates)	Failed (Y, N)	Impractical Because:
Seclusion/Restraint			
Special Precautions			
Other			
PROPOSED RETURN CRITERIA			
Behavior		Duration	
MAX SECURITY INFORMATION		Date Transfer Request/ Agreement Form Received:	
		Transfer Decision:	
		<input type="checkbox"/> Additional Information Required Prior to Decision:	
		<input type="checkbox"/> Transfer Approved, Planned Transfer Date:	
		<input type="checkbox"/> Transfer Denied Because:	
		Date Requesting RPH Informed of Decision:	
RETURN INFORMATION:		Date Patient Met Return Criteria:	
		Date Original RPH Notified:	
		Date Patient Transferred:	

COMMENTS:

ATTACHMENT B to ODMH Policy No. I-02

Addendum to ODMH Policy I-02, "Transfer Policy" Maximum Security Acute Care Service

A. Introduction:

1. The Ohio Department of Mental Health (ODMH) has identified a special need among its system of RPHs to provide an additional patient care/safety resource. From the group of patients receiving treatment in any of our six RPHs (located in seven sites in Ohio), there exists a small group of highly aggressive and violent patients who require a more structured and controlled treatment environment than is typically provided within our civil hospital environments.
2. For patient and staff safety reasons therefore, the Ohio Department of Mental Health will utilize the Timothy B. Moritz Forensic Unit (TBMFU) facility in Columbus to actively and intensively treat and stabilize patients with aggressive symptoms. The RPHs may utilize only up to six beds in TBMFU when the need for acute care in a maximum security treatment setting arises and beds are available in TBMFU. Each of the six RPHs shall be allocated one bed that they will share in the management of. The ODMH Medical Director shall always have one bed available in TBMFU.

B. Service Alternative:

When the six RPH beds are filled, the RPH capacity is filled. For any patient requiring the services of TBMFU when the six RPH beds are filled, the respective RPH (CCO/CEO) will be required to make a determination of which of their patients will be returning (refer to "Admission & Discharge Management" section).

C. Communication and Continuity:

The treatment and movement of patients between the patient's home hospital and the TBMFU will be carefully and safely managed so as to provide good continuity of services and communication for the patients and with the treating clinicians. (See attached communication flow sheet)

D. Admission Criteria:

The admission criteria for patients being transferred from the RPHs to TBMFU are contained in the ODMH policy I-02, "Transfer Policy".

E. RPH Admission and Discharge Management Process:

1. Each RPH shall have an allocation of beds (one per RPH) reserved for potential patients, if available.
2. Within each RPH's allocation, patients will be admitted if the CCO of the sending facility believes the patient meets criteria for maximum security (and after receiving approval from the Probate or Criminal Court as required). The TVBH CCO or designee shall accept all these referrals, so long as the patient is medically stable.
3. If the TVBH CCO believes any patient does not meet maximum security criteria, after a period of evaluation and observation or treatment, the TVBH CCO shall notify the

sending CCO of this opinion and data to support this opinion. The sending CCO will arrange for the prompt return of the patient. If there is disagreement with the recommendation to return the patient, the TVBH and the sending CCO will attempt to resolve this conflict. If no resolution is forthcoming, the TVBH CCO will request prompt resolution of this matter by the Office of the ODMH Medical Director.

4. RPHs may only exceed the allocation of one bed in TBMFU by:
 - a. Requesting use of one of the other designated RPH beds not being utilized and beds are available in TBMFU; or
 - b. Requesting use of the Medical Director's bed.
5. If an RPH exceeds its allocation and another RPH requests a patient admission within its allocation, the RPH over allocation must select one of its patients (after consultation with the TBMFU treatment team) to be returned within twenty-four hours to the sending facility. If it is not possible to return the selected patient within twenty-four hours due to legal delay then another patient from another RPH must be selected who can return within twenty-four hours.
6. Responses from the RPHs and the TBMFU for movement into and out of the program shall be prompt with an expectation of actual patient movement occurring within three business days of the request. Any prolonged delays or refusals in accepting or in returning a patient from and to the RPH, even when the RPH is within their designated bed capacity, will be brought to the attention of the ODMH Medical Director and Deputy Director.
7. For those patients with criminal court orders, the sending RPH will make arrangements for the necessary criminal court hearing, and request that the court provide a "two-way"/"round trip" journal entry so as to minimize delay time in moving patients back to the sending RPH.
8. Upon admission, TVBH medical staff assumes treatment responsibilities. The TBMFU attending psychiatrist and team social worker will provide frequent communication with the referring RPH (attending psychiatrist), to discuss and address relevant clinical issues.
9. The referring RPH will provide transportation to TBMFU. Sufficient belongings and personal effects for up to two weeks should accompany the patient. TVBH will supply the RPHs with a list of current restricted and contraband items.
10. The patient's medical record should accompany the patient upon transfer.

F. Legal Assurance:

The Legal Assurance Administrators (LAAs) are notified prior to any movements so that the respective courts are duly notified. All court hearings involving RPH patients at TBMFU are managed and communicated by the respective LAAs.

G. Medical Stability

Patients being scheduled for transfer must be medically stable. A patient's medical condition and continued treatment needs are part of the continuity of care discussions between the CCOs. The sending RPH CCO or designee shall alert the TVBH CCO of any

continuing medical needs, including pending or recommended consultations or needs for specialized medical follow up.

H. Admission Scheduling:

When possible, patient transfers to and from TBMFU should be scheduled Monday through Thursday during regular business hours to allow for the patient's adjustment prior to a weekend. Admissions and discharges are coordinated with the TVBH/TBMFU Contact Person and Legal Assurance Administrators. Otherwise, Monday through Fridays are admission days.

I. Service Focus/Transfer Criteria Back to the RPH:

1. The focus of the TBMFU service is Intensive Acute Care/Crisis Stabilization with a psychopharmacological approach.
2. Whenever a patient has reached maximum medical benefit at the TBMFU or whose behavior has been sufficiently stabilized for continued treatment in a civil hospital setting, the respective TBMFU treatment team will recommend to the respective CCO/ CEO of the RPH and the TVBH CCO and CEO that the patient be transferred back to the patient's RPH as the least restrictive treatment setting. Upon notification that the patient is transfer ready, the TVBH CCO will contact the RPH CCO to discuss the case and make plans for the patient's return transfer. The goal of treatment at TBMFU is to reduce or stabilize physically, acting out aggressive behaviors to the point of attaining a level of patient safety so that the patient can resume treatment at his/her home hospital.
3. The RPH will provide transportation services back to the RPH on the agreed upon return date.

J. Transfer Dispute:

Any dispute involving transfer to or from TBMFU will be referred to the ODMH Hospital Services Deputy Director and Medical Director, or their designees, for prompt resolution.

TWIN VALLEY BEHAVIORAL HEALTHCARE CIVIL TO MAXIMUM SECURITY COMMUNICATION FLOW CHART NARRATIVE FOR ADMISSIONS*	
1.	Referring/Home RPH sends "Civil to Maximum Security Request/Agreement Form" and a copy of the active chart to TVBH/TBMFU Contact Person.
2.	TVBH/TBMFU Contact Person notifies TVBH Chief Clinical Officer or designee for review and acceptance. Legal Assurance Office is notified by TVBH/TBMFU Contact Person.
3.	Legal Assurance Administrator (LAA) contacts LAA of sending RPH for legal information. TVBH Chief Clinical Officer or designee agrees to accept patient and notifies TVBH/TBMFU Contact Person
4.	TVBH/TBMFU Contact Person contacts Referring/Home RPH of acceptance. Additional old records may also be requested at that time.
5.	Chart material gathered and copied and sent to TVBH/Moritz Contact Person
6.	TVBH/TBMFU Contact Person arranges for copying of material once received from Home RPH and distributes to TBMFU Treatment Team.
7.	TBMFU Treatment Team reviews information and contacts Home RPH staff, (Physician to Physician, Psychologist to Psychologist, and others as needed).
8.	TBMFU Treatment Team develops initial Behavior Plan.
9.	TBMFU Treatment Team Unit staff receives information and training regarding Plan.
10.	TVBH/TBMFU Contact Person notifies Referring Home RPH Contact Person regarding readiness of transfer.
11.	TBMFU Treatment Team Unit environment is assessed for needs of patient.
12.	Home RPH set transfer date and makes arrangements.
13.	Patient transferred to TBMFU.

❖ **NON-EMERGENCY**

TWIN VALLEY BEHAVIORAL HEALTHCARE MAXIMUM SECURITY TO CIVIL COMMUNICATION FLOW CHART NARRATIVE FOR DISCHARGES TO HOME RPHs	
1.	TBMFU Treatment Team notifies TVBH/TBMFU Contact Person that patient is ready to return to Home RPH.
2.	TVBH/TBMFU Contact Person contacts TVBH Chief Clinical Officer or designee regarding Treatment Team decision. Legal Assurance Office contacted.
3.	TVBH Chief Clinical Officer or designee notifies Home RPH CCO that patient is patient is ready to be returned.
4.	Home RPH Contact Person is notified per TVBH/TBMFU Contact Person that patient is ready to return and arranges for chart material to be copied and sent.
5.	Home RPH Contact Person notifies Home RPH Treatment Team.
6.	Home RPH Treatment Team reviews chart material and makes contact with TBMFU Treatment Team. (Physician to Physician, Psychologist to Psychologist, and others as needed).
7.	Home RPH develops initial plan for patient's return to unit.
8.	Unit Staff are trained regarding Plan and unit environment prepared.
9.	Patient gets ready for move.
10.	Patient transferred.

Appendix I

Ohio Department of Mental Health

DOCUMENT NUMBER: MD-11
TYPE OF DOCUMENT: Guideline
AUTHORITY SOURCE: ORC Sections 5119.06 (A)(8), 5119.07, and 5122.271(F)
DOCUMENT TITLE: Guidelines for ODMH Regional Psychiatric Hospitals (RPHs) Informed Consent Policies
APPLICABILITY STATEMENT: All ODMH RPHs
"EXCEPTIONS" IF APPLICABLE: None
EFFECTIVE DATE: 8-17-2010
REPLACES: Guidelines for ODMH Behavioral Healthcare Organizations (BHO) Informed Consent Policies (6/1/01); Reviewed 12-01-02; 4-28-2006
DIRECTED TO: RPH Chief Executive Officers, Chief Clinical Officers, Nurse Executives, Client Advocates, Legal Assurance Administrators
DISTRIBUTED BY: Division of the Medical Director

Guidelines for ODMH RPH Informed Consent Policies

A. Purpose:

1. ODMH is dedicated to the development of informed consent policies that foster recovery, build on the therapeutic relationship between patient and physician, and respect individual rights, including the right to timely and appropriate treatment. Informed consent policies and practices acknowledge the judicial review established by law and set the standard for the mental health system.
2. ODMH has established criteria for ODMH RPHs to formulate informed consent policies based on more efficient methods to obtain necessary treatment for persons with mental illness which provide appropriate procedural safeguards, and recognize the RPH chief clinical officer (CCO) as responsible for matters relating to informed consent.

B. Critical aspects of ODMH RPH informed consent policies:

1. ODMH RPH policies on informed consent must be consistent with these guidelines. The following are key elements which must be contained in all informed consent policies. When unique local situations call for deviations, these exceptions must be reviewed by the ODMH medical director or designee prior to implementation.
2. Of special note is the fact that compulsory medical, psychological, or psychiatric treatment of any patient who is being treated by spiritual means through prayer

alone in accordance with a recognized religious method of healing is prohibited without specific court authorization, per ORC 5122.271(F).

C. Policy oversight and implementation

As a clinical policy, informed consent related policies should be under the auspices of the RPH CCO. As the managing officer for the RPH, all policies fall under the authority of the CEO to ensure implementation.

D. Informed consent policy

Each ODMH RPH shall have an informed consent policy applicable to all patients, outlining the process and procedures. RPHs are further encouraged to utilize mediation techniques to resolve informed consent issues. ODMH supports the use of a mental health advance directive for interested patients. Information about mental health advance directives will be available at each RPH.

E. Procedures and Treatments Requiring Special Informed Consent

Informed consent applies to procedures and treatments as well as medications. The following procedures and treatments require that informed consent be obtained in writing, and that the patient is provided with all information necessary to enable fully informed, intelligent and knowing consent.

1. Tooth extraction and other types of dental surgery;
2. Behavioral therapy plans;
3. Prescription medications;
4. Participation in research; and
5. All other non-routine or potentially hazardous treatments and procedures, such as surgery.

F. Routine Procedures and Treatments Requiring General Consent

The following procedures and treatments require general consent be obtained using the Admitting Treatment Permit, ODMH form DMH-0029 (found at <http://dmhext01.mh.state.oh.us/dmh/forms/efw.nsf/homepage?openform&Internal>):

1. All customary care, including psychological methods such as counseling, psychotherapy, evaluation and discharge planning.
2. Minor medical and minor dental treatment, including medical examination, blood draws, sutures for lacerations, reporting of potentially infectious diseases, and other notifiable conditions.

G. Emergency Medication

Each RPH should have a separate policy regarding emergency medication, defined as medication that, in the judgment of a physician, must be given urgently to avoid imminent harm to the patient or others. Policies regarding emergency medication should incorporate the following points:

1. Except in an emergency, patients on voluntary status may not be involuntarily medicated.
2. Use of medication solely to restrict freedom of movement, is prohibited; as with all psychiatric interventions, emergency medical interventions should be targeted at the underlying condition(s) producing the symptom(s) creating the emergency situation.
3. The physician's order should clearly indicate that the medication is being administered as an emergency, and the nature of the emergency situation should be clearly described in the progress note.
4. Any patient requiring the use of emergency medication three or more times in a seven-day period should be referred to the CCO for review, and the need for emergency medical intervention should be addressed in the patient's treatment plan. This level of review/documentation is not required for the non-emergency use of "prn" or "STAT" medication for which the patient has provided informed consent.

H. Persons Having a Guardian

1. Persons with a guardian have been determined incompetent by the probate court. "Incompetent" is a higher legal standard than "lacking capacity". RPHs are encouraged to work with both the person and the guardian to identify and utilize medication practices which provide the maximum benefit for the person.
2. Although providing information and seeking consent from all persons is essential, involuntarily committed persons who have a guardian may be treated with appropriate medication against their wishes if the guardian has given informed consent on behalf of the person. RPHs need to review the authority of the guardian to ensure that it includes medical decisions on behalf of the ward. If a person objects to a medication decision made by a guardian, the person may contact the Client Advocate for an explanation of any rights the person may have. In the event that a person files objections with the probate court pursuant to division (C) of section 2111.13 of the Revised Code, the RPH shall cease treatment of the person with medication except in an emergency pending court resolution. RPHs should consult with the Office of Legal Services in Central Office and the court of jurisdiction for further guidance on this issue if necessary.

I. Capacity Assessors

ODMH findings indicate that using the treating physician acting as capacity results in better communication between the patient and the physician. This is an important issue; the relationship between the patient and physician is a cornerstone of good care. It is up to the RPH whether or not the physician assessor is the patient's treating physician.

J. Review by the RPH CCO

Requests for involuntary medication are very important clinical decisions. All requests for involuntary medication must be reviewed and have approval by the RPH CCO before a petition is filed with the court. The RPH CCO may choose whether the review is based solely on documentation or if a face to face review is required. For those RPHs with multiple sites, the RPH chief clinical officer may delegate the review to the site CCO.

K. Court authorization for involuntary medication

All policies should outline those circumstances where court authorization is required to administer medication to a person involuntarily. This process should be outlined in a policy separate from emergency medication procedures or the informed consent process. Capacity assessment procedures, clinical reviews, independent evaluations and court approval mechanisms should be contained in this policy. The following provides guidance regarding court-authorized medication:

1. Persons who are involuntarily committed under ORC 5122.15: The request for involuntary medication should be filed with the probate court.
2. Persons who are admitted for a competency evaluation committed under ORC 2945.371(G)(3) or sanity evaluation - ORC 2945.371(G)(4): The RPH shall provide medications on a voluntary basis (either medication continuance or newly ordered medication based on current diagnosis and symptoms), or on an emergency basis. The RPH shall not seek a court order for involuntary medications for persons admitted for a sanity or competency evaluation.
3. Persons who are incompetent to stand trial - Unrestorable committed under ORC 2945.38(H)(4): the request for involuntary medication should be filed with the probate court.
4. Persons who are found not guilty by reason of insanity committed under ORC section 2945.40: these individuals are committed to ODMH through a municipal or common pleas criminal court, so the request for involuntary medication should be filed with the committing criminal court.
5. Persons found incompetent to stand trial - Unrestorable-criminal court jurisdiction who have been committed under ORC section 2945.39(A)(2): these individuals are under the jurisdiction of the common pleas criminal court, thus the request for involuntary medication should be filed with that criminal court.
6. Persons who have been found to be incompetent to stand trial- Restorable and committed under ORC section 2945.38(B): these persons remain under the jurisdiction of the municipal or common pleas criminal court that committed the person to the ODMH RPH. If the CCO determines that medication is essential to restore the defendant's competency and the patient lacks the capacity to give informed consent OR refuses medication, the CCO may petition the municipal or common pleas court to authorize involuntary administration of medication. Upon receipt of the petition, a hearing to address the issue will be held within five days in municipal court or within ten days in the common pleas court.
7. Persons who are terminated from an NGRI or IST-U-CJ status: these persons are subject to civil commitment pursuant to ORC Chapter 5122., for continued inpatient treatment if the civil commitment criteria are met. If this occurs, the individual would be treated as any other civil commitment and the request for involuntary medication should be filed with the probate court.

L. Independent evaluation

1. Policies should provide for a mechanism for the RPH to arrange for the person to have an independent evaluation upon request. The independent evaluator may or may not be a member of the RPH medical staff. For RPHs with multiple sites, it could be a physician who practices at another site than where the person is receiving services. RPHs may want to consider utilizing the Client Advocate to arrange for an independent examiner.

2. RPH policies and procedures should be consistent with these Central Office directives concerning informed consent and court-ordered medication. If in following these guidelines, the identified court refuses to hear the involuntary medication case, please contact the Office of Legal Services. The ODMH Medical Director is available for consultation regarding unusual situations.

Appendix J

Guidelines for Discharge of Persons on Conditional Release Commitment, Conditional Release Planning, and Conditional Release Report

Guidelines for Discharge of Persons on Conditional Release Commitment

Purpose

To provide guidelines for Forensic Monitors who are monitoring persons in the community on conditional release commitment. These guidelines should be utilized when planning for discharge from an ODMH Regional Psychiatric Hospital, when submitting required reports to the court, and when planning for the termination of the commitment.

Authority

In accordance with Section 2945.401(D)(1) of the Ohio Revised Code (ORC) when a defendant or person has been committed under Section 2945.40 or 2945.39 of the ORC, at any time after evaluating the risks to public safety and the welfare of the defendant or person, the Chief Clinical Officer of the hospital, facility or program to which the person is committed may recommend a termination of the defendant's or person's commitment or a change in the conditions of the defendant's or person's commitment.

Section 2945.401(J)(1) of the ORC further states that a defendant or person who has been committed pursuant to Section 2945.40 or 2945.39 of the ORC continues to be under the jurisdiction of the trial court until the final termination of the commitment. Final termination of a commitment occurs upon the earlier of one of the following:

- (a) The defendant or person no longer is a mentally ill person subject to hospitalization by court order or a mentally retarded person subject to institutionalization by court order as determined by the trial court;
- (b) The expiration of the maximum prison term or term of imprisonment that the defendant or person could have received if the defendant or person had been convicted of the most serious offense with which the defendant or person is charged or in relation to which the defendant or person was found not guilty by reason of insanity;
- (c) The trial court enters an order terminating the commitment under the circumstances described in division (J)(2)(a)(ii). That division states that the defendant is no longer a mentally ill person subject to hospitalization, and the trial court orders that the defendant's commitment is terminated during the pendency of the trial on the applicable offenses.

Procedures

Most individuals on conditional release commitment will continue in this status until the maximum prison term or term of imprisonment has been reached. The Forensic Monitor in collaboration with the court, shall devise a system to monitor the expiration dates for individuals on conditional release.

When an individual's expiration date is approaching, the Forensic Monitor should notify the trial court six weeks prior to the expiration date, or in a regularly scheduled hearing if the expiration time is approaching. The Community Mental Health or Alcohol, Drug Addiction and Mental Health Board for the county of the committing court and for the county of residence, if different, should both be notified at the same time.

The Forensic Monitor, the community mental health provider agency, the client and others as appropriate shall develop a post-termination treatment plan whose goals should include ensuring continuity of care and preventing relapse and/or future involvement with the legal system. The implications of the termination of the conditional release commitment shall also be explained to the individual in a manner that ensures that the person understands this information.

The court will issue a journal entry terminating the conditional release commitment. A copy of the journal entry should be sent to the Forensic Monitor who is responsible to notify the appropriate boards, the community mental health provider and the ODMH RPH (if the person was discharged from the hospital) of the termination. The Forensic Monitor shall complete the required Forensic Tracking and Monitoring System (FTMS) reports to the Ohio Department of Mental Health on these cases.

Conditional Release Planning Guidelines for Hospitalized Persons found NGRI and IST-U-CJ

I. Conditional Release Planning Process

- A. The conditional release planning process for persons who are NGRI acquittees and those found IST-U-CJ usually begins at the ODMH Regional Psychiatric Hospital (RPH) civil unit when this is deemed appropriate by the RPH treatment team, Forensic Monitor, and the community mental health provider.
- B. For an individual committed to a maximum security facility, the conditional release planning process will not begin until the individual is transferred to a civil hospital unit, unless extraordinary circumstances are present.
- C. The responsibility for conditional release planning should be shared by the RPH treatment team, the Forensic Monitor, and the community treatment provider who will provide mental health services for the person.
 1. A close working relationship between the community treatment providers, RPH treatment team and Forensic Monitor, sensitive to one another's concerns and perspectives, is essential to the efficiency of the conditional release planning process.
 2. The RPH LAA, social worker, treatment team coordinator, or a designee should ensure that the community treatment provider and the Forensic Monitor are informed about the time and location of treatment team meetings.

3. The RPH treatment team should, at each meeting, consider the patient's movement level, determine whether any changes to the risk assessment are needed, and assess the patient's progress toward conditional release.
4. It is expected that the Forensic Monitor's and community treatment provider's involvement in the treatment team meetings and the conditional release planning shall begin when the patient achieves Level 3 Movement. A high degree of involvement shall occur when the patient is being considered for, and after being placed on Level 5, Nonsecured Status.

II. Conditional Release Plan

A. The Conditional Release (CR) Plan shall:

1. Be developed with input from the RPH treatment team, Forensic Review Team (FRT), LAA, the Forensic Monitor, community treatment provider, and others as applicable.
2. Be a comprehensive plan and include all of the components described below in B.
3. Be reviewed by the patient with the community treatment provider, the Forensic Monitor and RPH treatment team. The patient should understand the conditional release plan and agree to follow the conditions of the plan.

B. The Components of a Conditional Release Plan shall include:

1. General conditions that apply to all persons on conditional release and the consequences for not complying with these conditions;
2. The specific conditions related to the individual's treatment plan including the management of unique risk factors presented by the person under consideration, along with the consequences for not complying with these conditions;
3. An Agency Agreement to Treat Form (See [Appendix BB](#)) signed by a representative of the community provider agency and the Forensic Monitor;
4. A plan to monitor compliance with the conditions of release and the individuals responsible for monitoring compliance, along with clearly defined actions that these individuals should take when noncompliance occurs; and
5. A release of information signed by the client allowing communication among the RPH, Forensic Monitor, community treatment agency, and any other entity involved in the treatment or monitoring of the individual.

C. The NGRI acquittee or person found IST-U-CJ shall sign the Conditional Release Plan which shall include the general and specific conditions as well as the consequences that will occur if the person fails to comply with the Conditions of Release.

- D. The Conditional Release Plan shall be reviewed and approved by the RPH Forensic Review Team (FRT). The FRT shall assess the thoroughness of the risk assessment and whether the Conditional Release Plan adequately addresses risk management issues in the community. The FRT/designee shall focus on whether all the required elements are included in the plan and whether all persons who should be involved in the process were involved.

- E. When the Conditional Release Plan is finalized and signed by all parties, the RPH LAA, or the Forensic Monitor if the person is not being discharged from the RPH, shall send a copy of the plan to all signatories plus the ADAMHS/CMH board whether or not the board signed the plan.

E. Template for Conditional Release Plan:

Conditional Release Plan for

_____(Name)_____
_____(Docket/Case Number)_____

Date Plan Submitted: _____

to

Judge _____ in the _____ County Court of Common Pleas

General Conditions:

I, _____ understand that I have been found by the Court to be (NGRI or IST-U-CJ) pursuant to Section (2945.39[A] or 2945.40) ORC and that I am being committed by the Court on a Conditional Release status. I understand that I will be expected to follow the conditions listed below in order to remain living in the community. I specifically agree:

1. to obey all municipal, state, and federal laws.
2. not to leave the state of Ohio without permission from the judge who maintains jurisdiction over my case.
3. to live at _____ (address) with _____ (name, relationship, if applicable). I agree not to change my address/living situation without approval of my Case Manager, _____ (name) _____, and Forensic monitor/designee, _____ (name) _____.
4. not to own, possess, or have access to firearms or any other illegal weapons.
5. to provide any release of information requested by my treating physician, case manager, Forensic monitor/designee, or other treatment staff concerning my mental health and compliance with the conditions of this Conditional Release Plan.
6. not to consume alcoholic beverages excessively or to abstain from them completely if that is a specific condition of my Conditional Release Plan. Excessive consumption is defined as that which disrupts or interferes with one's mental health, interpersonal relationships, employment, or proper community conduct.
7. not to use or possess any illegal drugs or prescribed medication unless it has been prescribed by my treating physician.
8. to follow the terms of my treatment plan and recommendations of the treatment team, whether or not they are specified in this Conditional Release Plan.
9. to complete any necessary forms for payment of services.
10. I understand that, even though I may not have violated any Conditions of Release, I may be hospitalized or placed in a crisis stabilization facility if my mental health deteriorates to such a point that hospitalization or stabilization is necessary for my safety and/or the safety of the

community. I understand that this hospitalization or placement may or may not result in a formal revocation of my Conditional Release status.

Specific Conditions (should be tailored to the individual's needs)

I agree:

1. to meet with _____ (Case Manager) at _____(address)_____, xx times per week/month for the purpose of monitoring compliance with the Conditions of Release. These meetings may include scheduled and/or random home visits.
2. to take all medications as prescribed by my treating psychiatrist, Dr. _____ at _____(agency name). I agree to meet with Dr. _____ (Psychiatrist) at _____(address), xx times per week/month for the purpose of monitoring my medication.
3. to cooperate with the collection of laboratory specimens including the testing of blood, breath, or urine for alcohol, illicit drugs, and therapeutic medication levels. I understand that some of these requests may be random and unscheduled.
4. to attend Alcoholics Anonymous and/or Narcotics Anonymous meetings _____ times a week and provide my Case Manager with proof of attendance.
5. to meet with Substance Abuse Counselor _____ at _____, xx times per week/month.
6. to cooperate with all requests for Psychological Testing.
7. to comply with any other special conditions deemed necessary by the mental health staff responsible for my treatment.
8. that if I am unable to attend a meeting or session as required by this Conditional Release Plan, I will provide advance notice by telephoning the person with whom I was scheduled to meet. If I am unable to contact this person, I will call one of the two following individuals:

Alternate Contact #1: _____
Telephone Number: _____

Alternate Contact #2: _____
Telephone Number: _____
9. to make arrangements for my transportation between my home and meetings required by this Plan. I understand that missing activities because of a lack of transportation will not be accepted as an excuse.
10. other conditions _____

Patient Agreement:

I have read or had read to me and understand and accept the conditions under which I will be released by the court. I agree to abide by and conform to them and fully understand that my failure to do so may result in:

- (a) revocation of Conditional Release,
- (b) modification of the Conditional Release Plan
- (c) notification of the Court and proper legal authorities,
- (d) emergency hospitalization, pursuant to Section 5122.10 of the ORC
- (e) arrest and prosecution

(Signatures)

Patient _____	Date _____
LAA _____	Date _____
Case Manager _____	Date _____
Forensic Monitor/designee _____	Date _____
SW/designee _____	Date _____
RPH Treatment Team Member _____	Date _____
_____	Date _____

- 11. Agency Agreement to Treat
(Agreement to be Attached)
- 12. Plan for Monitoring Compliance

Conditional Release Report Guidelines

In order for the trial court to render an informed opinion on the initiation or continuation of a conditional release commitment, the RPH, when recommending conditional release, or the facility or program to which the defendant or person has been committed, when recommending continuation of conditional release, shall supply a written report to the trial court. The reports recommending conditional release are submitted by the RPH whenever the hospitals consider such a legal status appropriate. The community reports regarding continuing conditional release commitment are submitted six months after the NGRI/IST-U-CJ finding (unless already completed during hospitalization), and every two years thereafter, or when the treating agency believes the person to be no longer mentally ill subject to hospitalization by court order. The community reports are completed by the treating agency, or upon issuance of a court order, by the Community Forensic Psychiatry Center.

The following is a guideline for an RPH report recommending conditional release and a community report recommending continuation or termination of conditional release.

1. Reason for Examination

- A. Identifying Data: name, age, date of birth, marital status
- B. Criminal charges for which the person was found NGRI or IST-U-CJ
- C. Referral Source: county, judge, court case number, type of court (Municipal or Common Pleas)
- D. Forensic Question: Recommendation for Community Conditional Release or Continued Commitment on Conditional Release, or Termination of Conditional Release, cite appropriate ORC section.

2. Examination Procedures and Sources of Information

- A. Date(s) of examination
- B. Place of examination
- C. Length of time of examination
- D. Indicate who was present during examination
- E. Explanation of limits of confidentiality, and the person's understanding or response
- F. Appraisal of the person's reliability as a reporter of information
- G. Psychological tests administered
- H. Sources of information:
 - hospital records
 - medical and mental health records
 - prosecutor's file (police reports, criminal history, witness statements)
 - school records
 - collateral interviews (family, friends, etc.)
 - contacts with defense attorney and prosecutor
 - contacts with forensic monitor/designee and community treatment staff

3. Background Information

(This section may be significantly abbreviated if prior reports to the court have adequately detailed the person's history and if the reader is referred to prior reports in the court's possession. Information which has been obtained since the last report was submitted should be added here.)

- A. Family Medical or Mental Illness History; unusual ethnic, religious or cultural beliefs in family in relationship to the law
- B. Child and adolescent development (brief)
- C. Education
- D. Military
- E. Employment
- F. Legal/Criminal involvement; juvenile and adult
- G. Substance Abuse
- H. Medical
- I. Psychiatric Hospitalization
- J. Mental Health Treatment

4. Course of Treatment in the RPH or Community

- A. Describe (in layman's terms) current psychiatric symptoms in the RPH, or since being placed on Conditional Release, or history of symptoms since the last report to the court. Describe medications prescribed (in layman's terms), method of delivery, any compliance difficulties, and the person's response to this form of treatment.
- B. Describe the person's level of participation in treatment and perception of need for treatment. Do not simply list all groups/activities attended.
- C. Discuss changes in dynamic risk factors and problems listed in the treatment plan (these risk factors and treatment plan problems should overlap considerably).
- D. Discuss medical issues, particularly if they have a bearing upon the level of risk in the community.

5. Mental Status Exam

- A. Appearance, speech, mannerisms, odd behavior
- B. Ability to relate to examiner, to listen and respond with relevant information, level of cooperation and defensiveness
- C. Mood: Depression or Mania symptoms
- D. Thought process disorder, inappropriate affect, thought content disorder (delusions, obsessions, etc.)
- E. Hallucinations
- F. Dissociative disorder or amnesic syndrome
- G. Orientation, attention, concentration, memory, ability to abstract, and intelligence level
- H. Judgment and Insight

6. Psychological Testing Results (if performed)

7. Diagnosis: DSM Axes I, II, III

8. Risk Assessment

- A. Identify both static and dynamic risk factors.
- B. Discuss the ways in which dynamic risk factors are to be addressed in the community if recommending conditional release, or have been addressed, managed and reduced in the community if recommending continuing conditional release.
- C. Describe the person's perspective on the CR plan and their willingness and ability to follow the plan's conditions.

9. Opinion and Recommendations

- A. State opinion within a reasonable degree of medical/psychological certainty regarding whether the person remains a mentally ill person subject to hospitalization by court order and the least restrictive treatment alternative.
- B. The diagnosis should be linked to the legal definition of mental illness. Refer to the statute (ORC 5122.01).

- C. The risk factors should be linked to the least restrictive treatment alternative.
- D. If the opinion is to continue on Conditional Release, recommendations should reflect whether the current course of community treatment should be maintained or changed; any revisions necessary to the conditional release plan needed to better manage risk factors.

10. Examiner's Signature, Degree, and Title/Profession

Appendix K

The rights of a person at a commitment hearing pursuant to ORC Section 2945.401 (C) or (D)(1) or (2), are found in ORC Section 2945.40 (C):

- (C) If a person is found not guilty by reason of insanity, the person has the right to attend all hearings conducted pursuant to sections [2945.37](#) to [2945.402](#) of the Revised Code. At any hearing conducted pursuant to one of those sections, the court shall inform the person that the person has all of the following rights:
- (1) The right to be represented by counsel and to have that counsel provided at public expense if the person is indigent, with the counsel to be appointed by the court under Chapter 120. of the Revised Code or under the authority recognized in division (C) of section [120.06](#), division (E) of section [120.16](#), division (E) of section [120.26](#), or section [2941.51](#) of the Revised Code;
 - (2) The right to have independent expert evaluation and to have that independent expert evaluation provided at public expense if the person is indigent;
 - (3) The right to subpoena witnesses and documents, to present evidence on the person's behalf, and to cross-examine witnesses against the person;
 - (4) The right to testify in the person's own behalf and to not be compelled to testify;
 - (5) The right to have copies of any relevant medical or mental health document in the custody of the state or of any place of commitment other than a document for which the court finds that the release to the person of information contained in the document would create a substantial risk of harm to any person.

Appendix L

OHIO DEPARTMENT OF MENTAL HEALTH GUIDELINE FOR COMMUNITY RISK ASSESSMENT OF PERSONS ON CONDITIONAL RELEASE

A. PURPOSE

This guideline provides to the community mental health system suggested procedures for clinical risk assessment of patients that carry a specific forensic legal status as defined below and who are conditionally released into the community. The risk assessment is an important part of the clinical record and will guide such activities as:

1. Treatment Planning,
2. Violence Prevention Planning,
3. Modification of Conditions of Release including Hospitalization and Revocation.

B. APPLICATION

This guideline applies to all Alcohol, Drug Abuse and Mental Health Services/Community Mental Health (ADAMHS/CMH) Boards, their designated Forensic Monitors, and Community Agency staff providing mental health services to the patients who carry a specific forensic legal status as defined below.

C. DEFINITIONS

“Forensic Legal Status” for the purpose of this guideline refers to persons found:

1. ORC 2945.39 (A)(2) Incompetent to Stand Trial-Unrestorable Under Criminal Court Jurisdiction (IST-U-CJ) and placed on Conditional Release pursuant to ORC 2945.401 and 2945.402, or
2. ORC 2945.40 Not Guilty by Reason of Insanity (NGRI) and placed on Conditional Release pursuant to ORC 2945.401 and 2945.402.

D. PROCEDURES

1. Clinical risk assessment and management of a patient on Conditional Release is the responsibility of the agency treatment team and/or clinician designated by the ADAMHS/CMH Board.
2. For all patients who are placed on Conditional Release directly from Court, an Initial Risk Assessment should be completed within 30 days after the patient is placed on Conditional Release. Additional information received after completion of the initial assessment should be appended to the initial risk assessment. A Community Risk

Assessment Update should be completed at least every 180 days thereafter throughout the Conditional Release Commitment.

3. For all patients who are released from an ODMH hospital to Conditional Release, a copy of the hospital's Initial Risk Assessment should be obtained by the agency treatment team and/or clinician designated to complete the Community Risk Assessment. A Community Risk Assessment Update should be completed within 90 days after the patient is placed on Conditional Release and at least every 180 days thereafter throughout the Conditional Release Commitment.
4. The Initial Risk Assessment consists of a thorough review of the current individual and family history, mental status and present condition of the patient; and a review of past mental health, juvenile justice, adult criminal, military, court, forensic center, and corrections records. Documented reasonable efforts should be made to acquire the above information.
5. A Community Risk Assessment Update should be completed on all Conditionally Released patients on the following occasions:
 - a. whenever an incident occurs which raises concern about whether the patient poses an increased risk of violence and, therefore, may be in need of increased risk management interventions. Such incidents include, but are not limited to, an increase in psychiatric symptoms, noncompliance with medication and/or other treatment, suicidal ideation, threatening comments, assault or property damage, weapon possession, substance abuse, arrest, or any other change in behavior which, for this patient, has been associated with violent behavior.
 - b. at least every 180 days (since the last Update).
6. The Initial Risk Assessment and Updates should be placed in the medical record. The Initial assessment and the two most recent Updates should not be removed from the current record.
7. Risk factors of special relevance should be identified and specifically addressed in the treatment plan.
8. The risk assessment forms and procedures may be used for any patient regardless of legal status. Such use is encouraged as an effective method of assessing and managing relevant risk factors for nonforensic status persons.

This guideline was originally issued by Dr. Michael Hogan to the ADAMHS and CMH Boards on 10-23-97.

Appendix M

Ohio Department of Mental Health

DOCUMENT NUMBER: I-12
TYPE OF DOCUMENT: Policy
AUTHORITY SOURCE: Ohio Revised Code Sections 5119.14 and 5122.26
DOCUMENT TITLE: Apprehension of Forensic Patients who Leave Grounds of a Regional Psychiatric Hospital
APPLICABILITY STATEMENT: Regional Psychiatric Hospitals
"EXCEPTIONS" IF APPLICABLE: None
EFFECTIVE DATE: 6-8-2010
REPLACES: L-09 (effective 10/9/98; Reviewed 5-8-2007)
DIRECTED TO: Regional Psychiatric Hospitals
DISTRIBUTED BY: Division of Hospital Services

Apprehension of Forensic Patients who Leave Grounds of a Regional Psychiatric Hospital (RPH)

A. Purpose

The purpose of this policy is to establish procedures whereby forensic patients in ODMH RPHs, upon or after unauthorized departure from RPH grounds, may be returned to RPHs by RPH police, under certain conditions.

B. Applicability: ODMH RPH staff and patients

This policy shall apply to all patients on forensic status in ODMH RPHs. "Forensic status" for the purpose of this policy includes the following:

1. Jail transfers and police holds;
2. Competency/sanity evaluation – O.R.C. Sections 2945.371(G)(3) and (4);
3. Incompetent to stand trial – Restoration Tx – O.R.C. Section 2945.38(B);
4. Incompetent to stand trial – Unrestorable – O.R.C. Section 2945.38(H)(4);
5. Maintain competency – O.R.C. Section 2945.38(A);
6. Incompetent to stand trial – Unrestorable – criminal court jurisdiction – O.R.C. Section 2945.39(A);
7. Not guilty by reason of insanity – O.R.C. Section 2945.40;
8. Mentally ill probationer or parolee – O.R.C. Section 2967.22 and chapter 5122.

C. Allowable Pursuit Off-Grounds:

1. ODMH police officers (or corrections officers, when applicable) may pursue a patient who meets the criteria in (B), above, if pursuit begins on RPH grounds, and only if all of the following conditions are met:
 - a. The patient is observed leaving the grounds; and
 - b. It is known that the patient meets the criteria in (B), above; and
 - c. Pursuit commences immediately after the staff observe the escape in progress.
 2. Verbal interventions should be used in an effort to secure the patient's consent to safely return to the RPH. No attempt to apprehend or physically restrain a patient should be made, unless at least two ODMH police officers are present and verbal interventions prove futile. Reasonable force may be used in apprehending the patient and returning him/her to the RPH. Pursuit shall not be continued if the patient goes into any of the following locations: a private residence, business establishment, farm building, or anywhere that a patient could obtain a weapon.
- D. When a patient who meets the criteria in (B) above, has left the grounds without authorization or has escaped as described in (F) below, the RPH police department shall immediately notify the Ohio State Highway Patrol (OSHP) and local law enforcement. In the same situation the RPH CEO or designee will immediately or as soon as practicable notify the appropriate prosecutor's office verbally and will then send a statement to the prosecutor notifying the prosecutor of the escape and the offense with which the person was charged or found NGRI.
- E. ODMH police officers may not go off RPH grounds to search for a patient who meets the criteria in (B) above if the patient escaped during transit to the RPH, escaped while being transported in a departmental or private vehicle during an authorized off-grounds activity, or escaped from authorized leave while off RPH grounds.
- F. If there is only one ODMH police officer on duty, there will be no off-grounds pursuit. Instead, the police officer will coordinate communications with OSHP and the appropriate local authorities.
- G. Any patient who meets the criteria in (B) above who is in the process of leaving RPH grounds without authorization, may be restrained with reasonable force and returned to the appropriate living area. If the patient does not leave RPH grounds, no notification of authorities outside of ODMH is necessary.

Appendix N

OHIO DEPARTMENT OF MENTAL HEALTH

Document Number: I-15
Type of Document: Policy
Authority Source: O.R.C. 5122.26
Document Title: AWOL Reporting
Applicability Statement: Regional Psychiatric Hospitals
"Exceptions" if Applicable: None
Effective Date: 10-19-2010
Replaces: MF-02 (Effective 4-16-2001; Reviewed 6-3-03, 4-28-2006)
Directed To: Regional Psychiatric Hospitals Staff
Distributed By: Division of Hospital Services

AWOL Reporting

A. Purpose

The AWOL Reporting policy was developed in order to provide a definition of absent without leave (AWOL) and a framework to assure uniform and consistent reporting from ODMH regional psychiatric hospitals (RPH) to Central Office.

B. Definition

"Absent without leave" and AWOL means a patient has been absent from a location defined by the patient's status regardless of leave or legal status. A patient is considered to be AWOL if the patient: (1) has not been accounted for when expected to be present; or (2) has left the grounds of the RPH without permission. Implicit in this definition is that the patient has been informed of the limits placed on his/her location prior to the AWOL or elopement incident.

C. AWOL Reporting Procedure

1. All AWOLs are reportable to Central Office as either "Minor", "Major", or "Critical Major" incidents. When a patient is AWOL (as defined above), RPH staff are required to identify this as an incident using procedures from the current rule 5122-3-13 of the Administrative Code (RPH Incident Reporting), and if applicable, the department's current Central Office Administrative Officer of the Day (AOD) policy, I-05. All AWOL data shall continue to be tracked internally by RPH procedures and monitored through quality improvement activities. Incident reports involving AWOLs shall include the time and date the patient eloped, when the patient was returned (or discharged), location where found, and a description of any pertinent/untoward activities/events that may have occurred while the patient was considered AWOL.
2. AWOLs as Critical Major Incidents.

Certain AWOLs are considered critical major incidents, as defined in the department's current Central Office Administrative Officer of the Day (AOD) policy. A critical major incident is an event for which there is an immediate need to advise the Deputy

Director of Hospital Services and the ODMH Director of the situation before the next working day. The following AWOLs are considered reportable as a Critical Major incident:

- a. The AWOL of patients considered at risk to self or others for which, because of their psychiatric history, criminal history, legal status, or current psychiatric condition or behavior (e.g., current federal charges, suspected of terrorist activity, threats against elected officials, the President, illegal immigration), there is a need to notify federal law enforcement (such as the Federal Marshall's office, FBI, Secret Service, Ohio State Highway Patrol or Homeland Security, respectively); or
 - b. Any AWOL not identified above, which based on the hospital's designated AOD or Chief Executive Officer (CEO) or Deputy Director's judgment, is deemed "critical" and needs to be reported as such (e.g., imminent threat to self or others, extreme adverse weather conditions, fragile medical status, etc.).
 - i. When a patient is AWOL and meets the Critical Major incident criteria, staff are to follow the reporting guidelines identified in the ODMH Central Office AOD Policy I-05.
 - ii. The RPH CEO shall report the AWOL critical major incident immediately to the ODMH Deputy Director via telephone, including incidents which occur outside of regular business hours.
 - iii. The Deputy Director can be reached by calling the Twin Valley Behavioral Healthcare, Columbus switchboard at 614.752.0333. Alternately, the reporting CEO or designee may contact the Deputy Director anytime through the cell phone.
3. AWOLs as Major Incidents.

When a patient falls under a certain legal status, or meets specific criteria, the incident is reportable as a Major Incident to Central office. These incidents fall within the categories, as defined below:

- a. Forensic AWOLs: All patients with a forensic legal status or tracked as forensic and listed below:
 - 2945.371(G)(3) - Competency Evaluation
 - 2945.371(G)(4) - Sanity Evaluation
 - 2945.38(B) - IST-R
 - 2945.38(H)(4) - IST-U
 - 2945.39(A)(2) - IST-U-CJ
 - 2945.401 - IST-U-CJ-CR
 - 2945.40 - NGRI
 - 2945.402(A) - NGRI-CR
 - 2967.22 - Parole/Probation
 - Police Hold/Capias
 - Jail Transfer
- b. Risk of harm to self or others: Any civil patient, who in the judgment of the Chief Clinical Officer is at risk of harming self or others, currently held on an emergency certificate, or adjudicated currently as at risk by the probate court [5122.01(B); 5122.15(C)]. Any patient considered at risk to self or others.

- c. Hospitals should follow the current incident reporting rule requirements for telephone reporting and the automated Patient Care System (PCS) Incident Notification Report system.

4. AWOLs as Minor Incidents

AWOLs not categorized as either Major or Critical Major Incidents shall be considered Minor Incidents (e.g., patients on a voluntary status who are not considered at risk to self or others). RPHs shall be responsible for maintaining information about AWOLs classified as Minor Incidents. All AWOLs classified as Minor Incidents shall be entered into the PCS Incident Report system, but no telephone reporting to Central Office is required.

5. Notice of Discharge Requirements for Forensic Patients

- a. In accordance with Section 5122.26 (A) of the O.R.C., the Chief Clinical Officer (CCO) of a RPH may discharge a patient who is under indictment, sentence of imprisonment, or on probation or parole and who has been absent without leave (AWOL) for more than thirty days, but shall give written notice of the discharge to the court with criminal jurisdiction over the patient.
- b. The statute also allows for the CCO to discharge any other forensic status patient who has been absent without leave for more than thirty days when written notice has been provided to the court of jurisdiction. For ODMH RPHs, this is applicable to the patients in the following forensic categories: NGRI, IST-U, IST-R, IST-U-CJ, Parolee/Probationer, Jail Transfer, Capias, and patients on conditional release status.
- c. The RPH shall also notify the ODMH Legal Division and the ODMH Office of Forensic Services of the planned discharge of all patients indicated in this section.

6. Discharge of Civil Patients

The CCO of a RPH may discharge any other (civil) patient who has been absent without leave for more than fourteen days.

7. External Reporting Requirements

- a. The RPH CEO is responsible for additional external notifications in certain cases. Based upon individual circumstances, and as required by other ODMH policy, other pertinent agencies or individuals may require notification.
- b. For external reporting purposes, the CEO is responsible for developing policies for the timely notification to the following of Critical Major and Major incidents of AWOL:
 - i. Ohio State Highway Patrol – local barracks; and local law enforcement; including information about persons the patient has threatened and RPH staff feel could be in danger;

- ii. Respective county prosecutor and local law enforcement agencies (forensic patients) in accordance with ODMH Policy I-12: Apprehension of Forensic Patients who Leave RPH Grounds;
- iii. In accordance with Section 2930.16 of the Ohio Revised Code, RPHs are responsible to notify victims or victim representatives upon the request of the victim or victim representative:
- iv. The respective community mental health board;
- v. Federal authorities such as Secret Service or the federal Marshall's Office involving federal offenders or federal offenses (see also paragraph (C)(1)(a) of this policy).
- vi. The ODMH Division of Hospital Services will monitor RPH AWOL information (incident reports) and data collection and provide aggregate reports including analysis of trends on a quarterly basis.

Appendix O

Ohio Department of Mental Health

DOCUMENT NUMBER:	MF-01
TYPE OF DOCUMENT:	Policy
AUTHORITY SOURCE:	Sections 2945.371 and 2945.38 of the Revised Code
DOCUMENT TITLE:	Competency to Stand Trial in ODMH RPHs
APPLICABILITY STATEMENT:	RPHs
"EXCEPTIONS" IF APPLICABLE:	None
EFFECTIVE DATE:	8-9-2011
REPLACES:	MF-05 Competency to Stand Trial Restoration Services in ODMH RPHs (7-15-2002; 8-12-2008)
DIRECTED TO:	ODMH RPHs
DISTRIBUTED BY:	Office of Forensic Services

Competency to Stand Trial in ODMH RPHs

A. Purpose.

1. To provide consistent quality competency to stand trial restoration services in all designated Ohio Department of Mental Health (ODMH) Regional Psychiatric Hospitals (RPHs).
2. Competency to stand trial in Ohio is defined as whether the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense (division(G)(3)(a) of section 2945.371 of the Revised Code).

B. Goal.

To attempt to restore persons to competency to stand trial in an effective and efficient manner within the ODMH RPHs.

C. Value Statement.

1. ODMH values the restoration of competency to stand trial for all individuals referred as incompetent to stand trial in order to improve the mental health of each individual, increase the autonomy of individuals to make rational decisions about their legal situations, improve reliability to the court process, and support the ethical administration of justice in our society.
2. Restoration should be completed in the least restrictive setting necessitated by the treatment needs of the individual defendant. Unless the severity of the alleged crime or the mental status of the defendant mandates the need for an inpatient setting for treatment, the defendant can and should receive restoration in an outpatient setting.
3. When RPHs have a defendant who is diagnosed with only a developmental disability (DD) the RPH CEO/designee should contact the Ohio Department of Developmental Disabilities (DODD) to develop a collaborative plan for the provision of services. ODMH Office of Forensic Services Community Forensic manager may be called upon

to assist in these cases and will be responsible to maintain a list of DODD employees/staff that may be contacted for these situations.

4. These guidelines address the recommended procedures for competency restoration. They can and should be followed apart from, or regardless of the level of care received by the defendant, i.e., whether the restoration care is provided in a RPH inpatient or a CSN community outpatient setting. Attachment A, "Competency To Stand Trial Restoration Process", demonstrates when in the defendant's care these recommended procedures apply to the inpatient and outpatient setting.

D. Principles.

1. Accurate initial diagnosis and effective treatment planning are essential to restoration of competency to stand trial.
2. Treatment plans must address the specific reasons (e.g., psychiatric, medical, cognitive) for the individual's adjudicated incompetency to stand trial.
3. RPHs must perform timely, objective, and appropriate restoration services.
4. A cross-disciplinary approach is often effective in providing competency restoration services.
5. Frequent and accurate competency to stand trial reassessments must be conducted in order that the court is notified of the individual's status in an expeditious manner and that inpatient resources are utilized appropriately.
6. Dual diagnoses situations (mental illness/developmental disabilities (MI/IDD) and substance abuse/mental illness (SA/MI) will be addressed in the treatment plan.

E. Competency to stand trial restoration program components.

1. At each RPH, there will be a Legal Assurance Administrator (LAA), and/or designated lead person, who will act as a liaison between the hospital staff and the county courts and sheriff's departments to ensure a timely and straightforward competency restoration process. The LAA will include in his/her duties:
 - a. Tracking the legal time frames for mandatory reports and court hearings on all competency restoration cases;
 - b. Notifying treatment teams and qualified examiners when evaluations and reports are due to the courts;
 - c. Reviewing the progress of each competency restoration case at regular pre-determined intervals;
 - d. Communicating with courts regarding dates of hearings, outcomes of court hearings and timeliness of court orders and journal entries; and
 - e. Communicating with the appropriate sheriff's departments regarding the individual's transportation to and from the hospital from jail and/or court.
2. The LAA will be the treatment team's contact person throughout the process of assessment, treatment, and restoration of the individual's competency restoration services as described below.

3. Assessment.

- a. An individual's competency to stand trial will be addressed in cross-disciplinary assessments on admission to the RPH since considerable time may have elapsed between outpatient examination and RPH admission. The individual's treatment team will reassess the progress toward competency restoration during regularly scheduled treatment team meetings. Periodic assessments allow the treatment team to measure whether its treatment interventions are working, and whether additional treatment elements need to be incorporated into the treatment plan.
- b. All formal competency to stand trial restoration evaluations must be conducted by a psychiatrist or psychologist examiner as defined in division (A)(2) of section 2945.37 the Ohio Revised Code.
- c. The development of an accurate diagnosis is necessary to plan treatment, and requires a comprehensive, unified history of the individual be obtained and documented.
 - i. Every effort will be made to obtain and review all relevant records within and outside of the ODMH system.
 - ii. Forensic reports pertaining to the alleged instant offense must be obtained and reviewed.
 - iii. Every effort will be made to obtain and review the prior legal record, current indictments and current police investigation summaries.
- d. Standardized psychological tests and forensic assessment instruments should be utilized when clinically relevant and appropriate.

4. Treatment.

a. Treatment Plan:

- i. Identify incompetency to stand trial as the first problem on the treatment plan.
- ii. List reasons for incompetency to stand trial.
- iii. Record goals and actions for improvement in each area contributing to incompetency to stand trial with designated treatment approaches and responsibilities of treatment team members.

b. Treatment Delivery:

- i. The cross-disciplinary treatment team shall coordinate and monitor treatment delivery and progress.
- ii. Derived from the assessment and as documented on an individualized treatment plan, treatment delivery should focus on the functional deficits relevant to incompetency to stand trial, using appropriate medication, individual and group therapy, education, and therapeutic activities.

- a. Oftentimes, defendants learn best when material is presented in multiple learning formats by multiple staff. For example, a simple lecture format may be replaced by or supplemented with learning experiences involving discussion, reading, video, visual cues, and experiential methods of instruction, such as role-playing or a mock trial.
- b. Defendants who are incompetent to stand trial due to specific knowledge deficits caused by low intelligence can often be restored to competency, but may require additional exposure to the educational material. This may be addressed by providing additional learning experiences.
- c. The curriculum of the competency restoration program should be individualized, but should include, at a minimum, the following educational topics:
 - i.* pending charges against the person;
 - ii.* severity of the pending charges;
 - iii.* sentencing possibilities;
 - iv.* plea options;
 - v.* plea bargaining;
 - vi.* roles of the courtroom personnel;
 - vii.* adversarial nature of the trial process;
 - viii.* evaluation of evidence;
 - ix.* the trial process;
 - x.* the ability to work with an attorney;
 - xi.* expected courtroom behavior;
 - xii.* discerning relevant from irrelevant facts.
- iii. If appropriate, the treatment team will attempt to involve the defense attorney either at the outset of treatment and/or as treatment progresses. This will help identify what, if any, the issues were in terms of the attorney/client relationship and will assist the patient in working with the attorney.
- iv. Defendants adjudicated as incompetent to stand trial may also lack the capacity to give informed consent with regard to treatment/medication issues or may refuse medication. Since medication may be an important component of restoration to competency to stand trial, it is essential that clinicians obtain proper authorization/consent for medication administration as soon as possible, in accordance with ODMH standards and local court practices.

5. Restoration.

- a. As soon as the treatment team notes sufficient restoration of competency to stand trial in the individual, or the inability of the individual to be restored to competency to stand trial within the legal time frame allowed by law, a formal reassessment of competency to stand trial by a qualified examiner (psychiatrist or psychologist) will take place. The formal reassessment of competency to stand trial should be completed by a qualified examiner who is not treating the individual unless staffing availability precludes this.
- b. The qualified examiner will provide a written progress note about the individual's restoration status. If the examiner disagrees with the treatment team's recommendations, details on the areas needing continuing treatment will be addressed in the progress note.
- c. Status reports must be submitted to the committing court at the following times per division (F) of section 2945.38 of the Revised Code:
 1. Whenever the examiner believes the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense;
 2. For a felony offense, fourteen days before expiration of the maximum time for treatment as specified in division (C) of section 2945.38 of the Revised Code, and fourteen days before the expiration for the maximum time for continuing evaluation and treatment as specified in division (B)(1)(a) of section 2945.38 of the Revised Code;
 3. For a misdemeanor offense, ten days before the expiration of the maximum time for treatment as specified in division (C) of section 2945.38 of the Revised Code
 4. At a minimum, after each six months of treatment;
 5. Whenever the examiner believes that there is not a substantial probability that the defendant will become capable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense if provided with a course of treatment.
- d. Report Content:
 1. The reports will include all of the following:
 - a. identifying data (of the defendant, legal charges, competency to stand trial status under the Revised Code, including a statement of the legal standard in division (G)(3)(a) of section 2945.371, and committing court);
 - b. collateral material reviewed;
 - c. explanation of the purpose of the examination and the defendant's understanding of this information;
 - d. pertinent history;
 - e. course of hospitalization in the RPH (including medication, therapies employed, response to therapy and competency restoration programming, unusual incidents);

- f. thorough mental status examination;
 - g. relevant, current DSM diagnostic classification;
 - h. assessment of factors related to competency to stand trial; and
 - i. the following requirements from division (G) of section 2945.38 of the Revised Code, including:
 - i. examiner's findings;
 - ii. facts in reasonable detail on which the findings are based;
 - iii. examiner's opinion as to the defendant's capability of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense;
 - iv. if in the examiner's opinion the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, whether there is a substantial probability that the defendant will become capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense if provided with a course of treatment;
 - v. if in the examiner's opinion the defendant remains mentally ill or mentally retarded; and
 - vi. if the maximum time for competency restoration has not expired, the examiner's recommendation as to the least restrictive treatment alternative that is consistent with the defendant's treatment needs for restoration to competency and with the safety of the community.
6. The RPH chief clinical officer (CCO) or designee has ultimate responsibility regarding the issue of restorability or documenting continuing treatment requirements for the treatment team.
- a. The CCO or designee may review formal reports of restoration or continued incompetency to stand trial and provide suggestions before they are forwarded to the court. The CCO or designee may obtain a second examiner opinion as needed.
 - b. The CCO or designee may ask for a clinical consultation in cases where difficulties with restoration to competency to stand trial have occurred. The clinical consultation should address recommendations for the treatment team to improve the chances of restoration. The consultation report shall be completed within thirty days and shall be a part of the medical record.
 - c. One of the following persons should perform the consultation:
 - i. a forensic psychiatrist in the RPH;
 - ii. a forensic psychologist at the RPH; or

- iii. a RPH forensic psychiatrist or psychologist consultant.
 - d. If all available consultants are already involved with the case, the LAA should refer the case to the Office of Forensic Services (OFS) for review. Review by OFS may include a clinical interview, depending on the circumstances of the case. If the treatment team and the consultant disagree about conclusions and/or the appropriate course, the treatment team should bring the matter to the attention of the RPH CCO through the proper channels for resolution within fourteen days.
- F. All applicable federal and state laws shall be followed throughout the implementation of this policy.
- G. Program Evaluation.
1. The RPH competency restoration program should include a system of data collection and standardized measures, allowing for the examination and continuous improvement of the program. These will be developed by the deputy director of Hospital Services (HS), in conjunction with the forensic service line.
 2. These will allow for comparison of the effectiveness of methods at different programs within HS (and possibly facilitate comparison to programs outside of HS). Systematic data collection will also permit a program, or all of HS, to present its programs and findings to a broader professional audience. The most basic outcome measures would be the percentage of patients restored to competency to stand trial (the number admitted for restoration and number successfully restored to competency to stand trial), adjusted for restoration intervals (function of severity of charges), the average length of time between admission and the determination that a patient was successfully or unsuccessfully restored, and the percent of court agreement with the conclusions.
 3. Sharing materials used across the RPHs for the teaching of competency-to-stand-trial-related topics will be encouraged through various forums such as state-wide forensic conferences and through the leadership of the forensic product line.

Appendix P

Guideline for
MEMORANDUM OF UNDERSTANDING
REGARDING CONTRACTS BETWEEN
COUNTY OF LEGAL RESIDENCE, COUNTY OF COMMITTING COURT
AND COUNTY OF SERVICE PROVISION

This Guideline is intended to assist ADAMHS/CMH Boards draft agreements concerning people who have been granted conditional release (pursuant to [2945.39](#), [2945.40](#) or [2945.402](#) of the Revised Code) by a trial/criminal court and have been either ordered or granted permission by the court to live in a county other than the county of the committing court.

Section [5122.01\(S\)](#) of the Revised Code defines “residence” in the following ways:

- (S) ‘Residence’ means a person’s physical presence in a county with intent to remain there, except that:
 - (1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained the person’s primary place of residence at the time the person entered the facility;
 - (2) If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed.

Thus, the various counties involved are defined as follows:

County of Legal Residence (home county)—the county of the person’s usual residence;
County of Committing Court—the county where criminal charges were filed;
County of Service Provision—the county where a person may be receiving mental health services, other than the county of legal residence or committing court.

In the vast majority of cases, the County of Legal Residence and Committing Court are the same. The individual’s usual residence is in the same county as the county where the charges were filed. The County of Committing Court has jurisdiction over the individual and may order that the individual receive appropriate treatment services at a community mental health agency in that county. The ADAMHS/CMH Board that serves the County of the Committing Court is responsible for monitoring and tracking the individual on conditional release. Conditional release to the community is a commitment status under which a person meets civil commitment criteria, but does not require hospital level care. The conditional release commitment may be continued by the criminal court for the length of time the individual could have been incarcerated if convicted of the most serious offense charged.

Problems may arise when the court either orders that the person on conditional release not live in the county of the committing court or permits the person upon his or her request to live in another county. In either case, the court will state in its written order that the person shall live in the specified county.

In such situations, the ADAMHS/CMH Board that serves the County of the Committing Court will seek to enter into a written agreement with the Board that serves the County of Service Provision, that is, the county where the person intends to live and receive services. It is the responsibility of the Board that serves the County of the Committing Court to fund the services provided in another Board area.

If the two Boards cannot enter into a *written* agreement for the provision of these services, then the person should not be permitted to live in the proposed County of Service Provision.

Usual reasons why the Committing Court County seeks services outside that county:

1. The mental health services recommended by the Regional Psychiatric Hospital are not available through the Committing Court county mental health board or agencies. (e.g. intensive treatment services or housing)
2. The Court wants to maintain distance between the individual and the victims of the offense.
3. The individual wants to be closer to family, other supports, or a job.
4. It is the personal preference of the individual.
5. The individual has made significant attachments to mental health services in the county where he/she was hospitalized.
6. Extensive adverse media coverage would be heightened in the County of the Committing Court reducing the chances for successful community reintegration.
7. Other risk factors are present for the individual (e.g. threats of reprisal)
8. The individual has criminal connections in the County of the Committing Court.

Reasons for a Board that serves the County of Legal Residence (*or Service Provision County) to refuse services requested by the Committing Court County:

- *1. The services requested in the conditional release plan are not available
- *2. Clinical expertise necessary to carry out the conditional release plan is not available.
- *3. Service programs are at maximum utilization (particularly residential and others—needs to be clearly documented).
- *4. No involvement (and disagreement) with the conditional release plan.
5. The person has been transient and actually has no home.
6. Family and/or prior victims prefer distance from the person
7. The individual has criminal connections in the County of Legal Residence.

Reasons for the Board that serves the County of the Committing Court to refuse to fund services proposed in the conditional release plan:

1. Disagreement with the conditional release plan to have treatment provided in the County of Legal Residence or in the County of Service Provision.
2. There are too few services mandated in the conditional release plan to be provided in the County of Legal Residence or the County of Service Provision.
3. The services to be provided in the County of Legal Residence or County of Service Provision are too many and/or too expensive.
4. There is a lack of funds to cover services proposed in the conditional release plan and are not funded by Medicaid or another third party. (Documentation needed.)

Disputes regarding contracts for services and/or monitoring should be worked out by the Boards involved. Boards should utilize the current residency dispute guideline, if applicable.

Additional Issues

1. Boards may wish to consider arrangements to share costs for ongoing community services if an individual is charged with a subsequent offense in a Legal or Service Provision county, which may become a second County of Committing Court.
2. Boards may wish to consider arrangements to establish or re-establish residency in their Legal or Service Provision county providing services according to eligibility requirements (e.g. Medicaid) to end the financial liability of the County of the Committing Court for the services (even though the monitoring responsibility remains with the Committing Court county).
3. The Forensic Monitor needs to be notified promptly by any treatment agency if there is any violation of the conditional release plan or breakdown in services. The Forensic Monitor needs to notify the committing court and assist the court in plans to safeguard the client and the public.

Example of a Board to Board Agreement

AGREEMENT BY AND BETWEEN THE CUYAHOGA COUNTY COMMUNITY MENTAL HEALTH BOARD AND THE LORAIN COUNTY MENTAL HEALTH BOARD

This agreement is entered into by and between the Cuyahoga County Community Mental Health Board (CCCMHB) and the Lorain County Mental Health Board (LCMHB).

ARTICLE 1.

The purpose of this Agreement is to specify services, costs and administrative duties associated with the provision of services for an out-of-county forensic client subject to criminal court jurisdiction. The individual who is the subject of this Agreement is: _____ (client name), Social Security Number: _____.

ARTICLE 2. Term

- 2.1 This agreement shall commence on January 1, 2008 and terminate on June 30, 2009.
- 2.2 Upon expiration, the Agreement may be renewed by mutual agreement; however, the terms of this Agreement may be changed.

ARTICLE 3. Services

3.1 General

- 3.1.01 After the CCCMHB Forensic Specialist, Carole Ballard approves the Individual Service Plan, (ISP) for the Consumer, LCMHB, by or through its provider agency, shall provide the following services:
- 3.1.01.1 Pharmacologic Management
 - 3.1.02.2 Community Psychiatric Supportive Treatment
 - 3.1.02.3 Crisis Intervention Mental Health Service
 - 3.1.01.4 Drug Screens

ARTICLE 4. Costs and reimbursements

4.1 Non-Medicaid

- a. Consumer is in need of non-Medicaid services, and the CCCMHB will pay only for those non-Medicaid services that are approved by the CCCMHB Forensic Specialist and are identified in the ISP, as delineated in Paragraph 3.1 of this Agreement.
- b. LCMHB shall submit monthly invoices, via e-mail to _____@_____ which is to be received on or before the 15th of each month, to the CCCMHB Forensic Specialist, detailing the units of services rendered, cost per unit, dates of service and other relevant information.
- c. The CCCMHB shall pay the properly submitted invoice within thirty (30) days of the CCCMHB Forensic Specialist's approval.
- d. The total value of this Contract shall not exceed \$xx,xxxx.00

ARTICLE 5. Continuity of Care

CCCMHB and LCMHB shall work together in advance planning for the transition of Consumer into services provided through LCMHB upon termination of this Agreement.

ARTICLE 6. Dispute Resolution

Any issues in dispute regarding the terms or implementation of this Agreement shall be first referred to the Executive Directors of the parties for resolution. The current ODMH Residency Dispute Process will be utilized if applicable. Problems requiring additional intervention will be referred first to an outside and certified mediator, and lacking resolution through that process, to the appropriate ODMH Area Director(s) for resolution.

ARTICLE 7. Amendments by Agreement

This Agreement may only be amended, modified, or extended by the mutual written agreement of the parties hereto, in a writing signed by both parties, to be attached to and incorporated into this contract.

ARTICLE 8. Entire Agreement

It is acknowledged by the parties hereto that this Agreement supersedes any and all previous written or oral agreements or understandings between the parties concerning the subject matter of this contract.

ARTICLE 9. Severability

Should any portion of this Agreement be deemed unenforceable by any administrative or judicial officer or tribunal of competent jurisdiction, the balance of this Agreement shall remain in full force and effect unless revised or terminated pursuant to the terms of this Agreement.

ARTICLE 10. Waiver

No waiver of any breach hereof or default hereunder shall be deemed a waiver of any subsequent breach or default of the same or similar nature.

IN WITNESS WHEREOF, the parties hereto have caused two copies of this Agreement to be executed by their duly authorized officers.

THE CUYAHOGA COUNTY COMMUNITY
MENTAL HEALTH BOARD

LORAIN COUNTY MENTAL
HEALTH BOARD

CEO

Executive Director

Date

Date

Appendix Q

Ohio Department of Mental Health

Document Number: MF-05

Type of Document: Guideline

Authority Source: ORC Sections 5119.06, 5119.57, and 5120.17 and ORC Chapter 2945; ODMH Operational Need

Document Title: Guidelines for Correction Inmates with Additional Legal Statuses

Applicability Statement: All Employees

“Exceptions” If Applicable: None

Effective Date: 6-14-2011

Replaces: ODMH: 21 (11-6-96); 10-20-1998; 10-13-2000; 10-18-2002; 4-28-2006

Directed To: All Employees

Distributed By: Office of Forensic Services

Guidelines for Correction Inmates with Additional Legal Statuses

A. Purpose:

The purpose of this policy is to establish guidelines to track individuals with a forensic legal status who are sentenced to an Ohio Department of Rehabilitation and Correction (ODRC) facility.

B. Definition:

Forensic Legal Status: for the purpose of this policy, forensic legal status refers to:

1. Commitment under division (A)(2) of section 2945.39 of the Ohio Revised Code (ORC) as Incompetent to Stand Trial-Unrestorable-Criminal Court Jurisdiction;
2. Commitment under section 2945.40 of the ORC as Not Guilty by Reason of Insanity;
3. Commitment under Section 2945.402 of the ORC as Incompetent to Stand Trial-Unrestorable-Criminal Court Jurisdiction on Conditional Release or Not Guilty by Reason of Insanity on Conditional Release.

C. Guideline:

1. When an individual with a forensic legal status who is in an ODMH facility or on conditional release commitment in the community is sentenced to an ODRC facility, the Legal Assurance Administrator (LAA) when a person is in an ODMH facility, or Forensic Monitor when the person is in the community, shall notify the prosecutor to

file a detainer. The inmate's penal status will have precedence over the forensic legal status.

2. Placement in the appropriate level of mental health care in the correctional setting is the responsibility of the ODRC classification process.
3. The ODMH Manager of Community Forensic Programs is notified in writing about the detainer by the hospital LAA or the Community Forensic Monitor. A copy of the journal entry is included when available. The Manager of Community Forensic Programs shall notify the Community Linkage Program Manager who shall develop a tracking system to monitor inmates with a forensic legal status that are reported to them. When an inmate, on whom a detainer has been filed, is scheduled to be released from an ODRC facility, the Community Linkage Social Worker covering the inmate's institution will inform the Community Linkage Program Manager of the inmate's name and scheduled date of release. This notification will occur at least fourteen days prior to the inmate's scheduled release. The Community Linkage Program Manager will notify the Community Forensic Monitor and/or the LAA and Manager of Community Forensic Programs in writing prior to the release of the inmate from an ODRC facility. The Community Forensic Monitor and/or the LAA will notify the prosecutor of the individual's planned release from prison.
4. Pursuant to statute, the prosecutor is required to notify the criminal court of the jurisdiction at the time that each of these inmates has completed his or her prison sentence. Upon the individual's release from prison, there is a court hearing required by statute. The court determines whether the person remains under the commitment pursuant to division (A)(2) of section 2945.39 or section 2945.40 of the ORC, and if so, the court will then determine the most appropriate placement for the individual.
5. The criminal court may wish to obtain an evaluation pursuant to sections 2945.401 and 2945.402 of the ORC, from a community forensic psychiatry center in order to determine the person's current mental status, eligibility for continuing commitment under division (A) of section 2945.39 or section 2945.40 of the ORC, and the least restrictive alternative for continuing treatment if the maximum time for commitment has not expired.
6. Pursuant to division (A) of section 2945.401 of the ORC, individuals committed under division (A) of section 2945.39 or section 2945.40 of the ORC shall remain under the jurisdiction of the criminal court until the final termination of the commitment as described in division (J)(1) of section 2945.401 of the ORC. The court then determines if the jurisdiction is terminated because of the expiration of the maximum time for commitment.
7. In cases where the maximum time for commitment has expired, the criminal court may wish to cause an affidavit to be filed in the probate court if appropriate to the person's current mental condition.

Appendix R

Ohio Department of Mental Health

Document Number: MF-06
Type of Document: Policy
Authority Source: Operational Need
Document Title: Assessment of Patients in Regional Psychiatric Hospitals for the Purpose of Determining whether to File Criminal Charges
Applicability Statement: Hospital Services and Regional Psychiatric Hospitals
"Exceptions" if Applicable: None
Effective Date: 3-17-2009
Replaces: Memorandum: Prosecution of Hospital Patients who Inflict Injury to other Persons or Destroy Property, effective 12-30-83; ODMH: 19 - Filing Criminal Charges Against Patients in ODMH Hospitals, effective 8-14-95; 98-53 effective 9-3-99; Reviewed 2-1-2002; 4-28-2006.
Directed To: Hospital Services and Regional Psychiatric Hospitals
Distributed By: Office of Legal Services; Office of the Medical Director; Office of Forensic Services

Assessment of Patients in Regional Psychiatric Hospitals for the Purpose of Determining whether to File Criminal Charges

A. Purpose

To guide regional psychiatric hospitals in deciding whether to conduct clinical assessments and file criminal charges against patients who allegedly commit criminal acts in hospitals and CSNs, while protecting the rights of the alleged patient-perpetrators.

B. Guidelines

1. Patients in ODMH hospitals are most frequently admitted because they demonstrate the symptoms of mental illness and are a danger to self or others. Occasionally, these traits manifest themselves within the hospital setting in the form of physical or sexual assault, threatening or menacing behavior, extensive property damage or other alleged criminal behavior directed toward other patients, employees, or the facility. When such untoward incidents occur, coincident with police investigative procedures, it is often appropriate to address the situation within the hospital structure through clinical interventions (changes in the treatment plan of the allegedly offending patient such as crisis intervention strategies, medication changes, seclusion or restraint, or geographic unit changes). Those who are offended against should be helped with timely medical care, crisis intervention, respite, reassurance and support, or additional training as indicated.

2. When any alleged criminal behavior occurs, the issue arises as to whether to assess the person to determine whether or not to file criminal charges against an allegedly offending patient for illegal behavior against person or property. Any alleged employee victim or alleged patient victim has the individual right to contact their local prosecutor if the individual chooses to do so. The alleged employee victim or alleged patient victim will be informed of this right and given support by the hospital administration. Guardians of alleged patient victims should be notified to consult on a course of action for their wards.

C. Procedure

When incidents of probable criminal behavior by inpatients in a hospital occur, the following procedure should be followed.

1. Incidents of probable illegal behavior, including but not limited to situations in which there is significant injury to others, significant menacing or serious threats, or substantial property damage, shall be immediately reported to the hospital police chief or designee, CEO, chief clinical officer (CCO), and the client rights advocate (CRA).
2. These incidents shall also be reported as required by the ODMH incident reporting rule, OAC Rule 5122-3-13, "Incident Reporting."
3. The police departments of ODMH hospital sites have arrangements with their respective State Highway Patrol posts and prosecutors' offices. In general, the hospital police department at that site notifies the State Highway Patrol about all probable felony level offenses. The State Highway Patrol investigates serious felony offenses and presents the evidence directly to the county prosecutor's office, after which the prosecutor decides whether or not to seek an indictment. Hospital police generally investigate alleged misdemeanor offenses.
4. Clinical examination
 - a. Within twenty-four hours of a reported incident, the CCO may cause to be performed, an examination of the allegedly offending patient. An examination, although not mandatory, should be performed unless 1) the CCO and CEO jointly determine that the probable criminal behavior is minor in nature, or 2) the CCO determines that the probable criminal behavior is a direct result of active mental illness symptoms as documented in the medical record. The examination should be conducted by a psychiatrist or psychologist not currently treating the alleged patient offender or alleged patient victim. The examining psychiatrist or psychologist shall explain to the alleged patient offender that the results of this examination will be shared with hospital administration and may be used to make a decision about filing charges. The examination should be preceded by the following disclosures to the alleged patient offender:
 - i. The purpose of the examination;
 - ii. The right of the patient (or guardian, if applicable) to refuse the examination or to refuse to answer questions;
 - iii. The right to consult with a representative (Ohio Legal Rights Service, private attorney, CRA, family member or significant other);

- iv. The fact that the results of this examination may be disclosed under reasonable circumstances by the CEO, in consultation with the ODMH Office of Legal Services, Ohio State Highway Patrol and/or the local prosecutor's office, if requested.

A notation regarding each of the preceding disclosures is to be documented in the patient's medical record.

- b. If the patient refuses the examination or refuses to answer specific questions, the examiner should inform the patient that absent this examination or specific responses to questions, decisions about filing charges will be based on other available information.
- c. If the psychiatrist or psychologist assesses the patient as lacking capacity to understand the purpose of the examination and his/her legal rights, a note to that effect shall be made in the medical record and no examination, as described in section (C)(4)(d), shall take place. If the patient has a guardian, the guardian should be informed of the purpose of the examination and legal rights involved prior to the examination.
- d. The examination should focus on:
 - i. The circumstances of the incident;
 - ii. Identification of any victim(s) (using patient or employee codes, where applicable, to preserve confidentiality to the greatest extent possible);
 - iii. Medical issues such as medication effects or side effects or neurological conditions influencing the incident;
 - iv. A thorough mental status examination with particular attention to any disorientation or confusion, delusions, hallucinations, amnesia or dissociative disorders, or substance use associated with the incident prompting this examination; and
 - v. An assessment of rational or irrational motives for the incident.
- e. No legal conclusions shall be drawn (competency, NGRI, etc.) as a result of this examination. However, in the report, the examiner may recommend whether or not to file criminal charges.
- f. The examination shall be dated, timed, and placed in the patient's medical record. This becomes part of the patient's record, which is the property of ODMH and is generally confidential under state law. Under appropriate circumstances, however, as described in (C)(4)(a)(iv) of the "Procedure" section, the examination may be released.

4. Decision-making

- a. Following the completion of the after-incident examination, the CCO or his/her designee shall review the case in terms of the nature of the allegedly offending behavior, precipitating factors, a review of the patient's history as contained in the medical record, the after- incident examination, and treatment options available.

- b. The hospital police chief shall review police reports and any State Highway Patrol reports available. The CCO and the hospital police chief shall present their findings to the hospital CEO including whether or not the State Highway Patrol or the victim(s) have filed or intend to file charges.
- c. If charges have not already been filed, the CEO, after review of the CCO and hospital police chief presentations, and any other consultation which would be helpful (including the ODMH medical director, Office of Legal Services, or security consultant), shall decide if filing charges is warranted and in the best interest of the hospital. The CEO shall take into account the probability of the alleged offending patient's competency to stand trial, the relationship between the alleged acts and the individual's mental illness, the probable outcome of prosecution, and the impact on the offending patient, other patients, and staff.

5. Notification

If the CEO pursues filing of charges, the following persons shall be notified:

- a. The allegedly offending patient (and his/her guardian);
 - b. The alleged victim(s) (and guardians of alleged patient victims);
 - c. The parents/spouse, legal guardian, or legal custodian of the alleged patient-offender and alleged victim (if a patient), pursuant to authorization requirements of OAC Rule 5122-3-13 (D)(5)(i), "Incident Reporting."
 - d. The alleged patient perpetrator's and alleged patient victim's (if applicable) treatment teams;
 - e. The CRA;
 - f. The Legal Assurance Administrator;
 - g. The Offices of the Medical Director and Security Consultant of ODMH.
6. If the filing of charges is not pursued, the hospital police department, upon the request of a victim or victim's guardian, shall provide information to assist in individually contacting the local prosecutor.

Appendix S

Legal Assurance Administrator Duties and Responsibilities

Each ODMH Regional Psychiatric Hospital (RPH) designates a Legal Assurance Administrator (LAA) who has specific duties and responsibilities related to forensic status patients. The LAA has become the primary liaison between the RPH and the criminal justice system, the community Forensic Monitors, the community mental health system, ODMH Central Office, and other agencies involved with forensic mental health services.

The LAA generally becomes the “local” expert on forensic-related issues, developing a relationships with the local court system(s) and other agencies involved with this population by providing guidance, consultation and information.

Outlined below are the major duties and responsibilities of the LAA. The LAA:

- Is responsible for being knowledgeable about current ODMH policies, procedures, and guidelines, the Ohio Revised Code, and the RPH’s policies and procedures.
- Is the primary liaison between the RPH and the criminal justice system. Schedules, coordinates, and monitors forensic admissions, discharges, transfers, and movement levels as related to legal and security issues.
- Responds to questions from judge(s), court personnel and attorney(s) as appropriate, and provides a link to additional resources when indicated.
- Assures the accuracy of journal entries and verifies information through the judge, court personnel or the prosecutor as needed.
- Provides follow-up to questions related to forensic issues at the RPH. May consult with the involved court or attorney(s), the ADAMHS/CMH Board, ODMH Legal Counsel, the ODMH Office of Forensic Services, law enforcement agencies, parole or probation officers, or other agencies as necessary for gathering information and resolving problems.
- Is responsible to prepare, coordinate or monitor written and verbal communications between the RPH staff, patients and the court system.
- Ensures that court-ordered evaluations and reports for initial, full and mandatory hearings are completed in the time allowed, and maintains contact with the courts.
- Initiates the request and further coordinates Nonsecured Status (Second Opinion) evaluations with the local community forensic psychiatric center.
- Consults with treatment teams and professional staff regarding legal/forensic issues, journal entries, ODMH and RPH policy regarding forensic movement and transfer of forensic patients.
- Consults with Chief Clinical Officer (CCO) and/or Chief Executive Officer (CEO) on problems or concerns, reviews policies and procedures and makes recommendations for revision.
- Maintains statistical data and prepares reports for the RPH CEO, CCO, and ODMH. Provides feedback on problem areas as indicated.
- Maintains current information on forensic policies and procedures, the Ohio Revised Code and current statutes, along with ODMH directives. Consults with CEO and/or CCO on problems and provides a recommendation for resolution.

- Is responsible to gather collateral information from prosecutors, defense attorneys, courts, law enforcement agencies and community agencies for the purpose of assisting staff in preparing forensic reports and risk assessments.
- May participate in the development of training programs and in-service training for staff on topics related to legal and forensic issues.
- Serves on RPH committees as appointed, including the Forensic Review Team. Attends regular RPH LAA meetings with OFS, relays related information to RPH leadership, and may participate on statewide ODMH committee(s) and/or activities. Provides feedback to OFS on ODMH policies, procedures, guidelines and directives.
- Monitors Forensic Patient AWOLS and reporting as required, and ensures that the data in the Patient Care System (PCS) AWOL Reporting System is current. Maintains or oversees the input of data into the PCS Forensic Movement Level screens, and all other Forensic Screens in PCS.
- Maintains contact with the Courts, the community Forensic Monitor/designee, and the responsible ADAMHS/CMH Board as required for admission, discharge and transfer of forensic patients. Supports the continuity of care for forensic status patients who move between the RPH and the community through communications with the Court and community mental health representatives prior to conditional release, upon a patient's return from conditional release, and by monitoring the follow-up data from the Forensic Monitors on persons discharged on conditional release.

Appendix T

**Inpatient and Outpatient
Residency Determinations Guidelines**

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Residence Determination and Dispute Process for Inpatient Services: Guidelines for ODMH Behavioral Healthcare Organizations and CMH/ADAMHS Boards

Purpose

The purpose of these guidelines is to establish procedures to determine the county of residence with respect to inpatient services. These guidelines are to be implemented in a way that is in the best interest of persons served, and in a manner that respects the expressed wishes of individuals with respect to residence.

Background

The definition of residence for financial purposes under Chapters 5119 and 5122 of the Revised Code is set out in ORC Section 5122.01(S), which states as follows:

"Residence" means a person's physical presence in a county with intent to remain there, except that: (1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained his primary place of residence at the time he entered the facility, or (2) committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401 or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed. [Except for persons civilly committed after a finding under 2945.38(H)(4)].

When a **college student** is seeking inpatient services, residence is the county where their parents live, if student is claimed as a tax dependent on their parents' return. If the student is emancipated, at a graduate level of study or has dependent children, the student should have further screening to determine actual county of residency. If the student is from out of state, the criteria used for out of state residency determination should be used.

When a **homeless person/legal migrant** seeks inpatient services, residence is the county where they reside as homeless or otherwise.

When a **transitional homeless person**, whose residence is unknown and cannot be determined, seeks inpatient services, residence is the county where they present for services.

When a person from **out of state/illegal migrant** seeks inpatient services in a state-operated Behavioral Healthcare Organization (BHO), residence is the county where the BHO is located.

Dispute Process

With respect to the **dispute of a person's residence**, Section 5122.01(S) states:

When the residence of a person is disputed, the matter of residence shall be referred to the department of mental health for investigation and determination. Residence shall not be a basis for a board's denying services to any person present in the board's service district, and the board shall provide services for a person whose residence is in dispute while residence is being determined and for persons in an emergency situation.

Disputes may arise in connection with two (2) types of circumstances, the first being when a person has been hospitalized and the second is when a person presents himself or herself in a given county and requests or otherwise is in need of mental health services. The Dispute Process set out below addresses the process for inpatient residency disputes. The outpatient residency dispute process is described in the section entitled, "Guidelines and Operating Principles for Outpatient Residency Determinations Among CMH/ADAS/ADAMHS Boards" that begins on page 7 of this document.

Dispute Process

1. Any community mental health agency, which provides a prescreening service, must, as part of such service provided to an individual, determine the person's county of legal residence in accordance with ORC 5122.01(S). The prescreening service must ensure that written information indicating the person's county of residence accompanies any person admitted to an ODMH BHO along with the UCI number.

2. The ODMH BHO to which a person is admitted shall assign a county of residence for all persons admitted based on the information provided in 1) above, or upon its own determination if such information is insufficient or in error. This information will be documented in the Patient Care System (PCS) within two hours of admission. Each board is responsible to monitor new admissions on a daily basis and submit the UCI number if not provided at prescreening.

3. If the community mental health board to which the hospitalized person has been assigned objects to the determination of residence, the board may investigate the issue of the person's residence and must notify the board whose service district the assigned board feels is the person's residence. Such notification must occur within ten (10) calendar days of admission and must include a written statement of reasons for the dispute of residence. At the same time, the assigned board must also copy the Chief Executive Officer (CEO) of the BHO on any dispute.

4. The boards identified in 3) above must negotiate the issue of the person's county of residence. This negotiation must occur within ten (10) calendar days of the notification made in 3) above. If the negotiation results in agreement that the person's residence is the initially assigned board or an alternative board, both boards must notify the BHO immediately of the correct assignment of residence. The board assigned in 2) above will remain the board of residence until another board notifies the BHO in writing that it agrees to be assigned as the board of residence or until the CEO or Area Director (AD) make a different determination as described in 6) or 7) below. Until such change, the board assigned residence in 2) above shall be responsible for discharge planning, case management, and other critical services, and no patient shall be kept in a BHO or be denied services by the board assigned residence due to a pending dispute.

5. If the matter of residence is not resolved in 4) above, the objecting board may notify the BHO CEO of its objection by mail, or facsimile. The objection must specify the hospitalized person's name, age, last residence, and length of time in that residence;

the reasons for the objection; and persons to be contacted at the board about the objection. Within three (3) calendar days of receiving the objection, the BHO CEO shall arrange a conference call with all persons available and necessary to provide information in order to make a final determination. Every effort should be made to have the hospitalized person participate in the conference call. If the hospitalized person cannot participate, the CEO must attempt to obtain the wishes of the person prior to the conference call.

6. Within twenty-four (24) hours after the conference call in 5) above, the CEO of the BHO shall notify all affected parties of the determination of county of residence. In making a determination, the CEO shall accept the hospitalized person's statement of residence unless there is clear evidence to the contrary. The CEO shall be responsible for ensuring that any change in residence resulting from the determination is entered into the Patient Care System.

7. The board assigned residence in 6) or the hospitalized person may request reconsideration of the BHO CEO's determination. Such request must be made within three (3) calendar days of the determination and must be based on significant errors in judgment or fact. The reconsideration request must be made in writing to the AD for the BHO in which the person is hospitalized and the AD may accept or deny the request based on the extent to which it is made clear that the request is based on significant errors in judgment or fact. If the request is accepted the AD must make a final determination and notify all affected partners within three (3) calendar days of the request. In making a determination, the AD shall accept the hospitalized person's statement of residence unless there is clear evidence to the contrary. The final county of residence determination must be communicated to the CEO, who is responsible for ensuring that any change in residence is entered into the Patient Care System.

8. The board assigned residence shall remain responsible for services until final determination as in 7). Until such a change, the board assigned residence shall be responsible for discharge planning, case management, and other critical services, and no patient shall be kept in a hospital or be denied services by the board assigned residence due to a pending dispute. If steps 1 - 7 result in a change of assigned residence, the new board shall be responsible for the patient's care, including service delivery and payment for inpatient care, from the day of admission.

Determining Residency and Financial Responsibility for Individuals with a Forensic Status

An individual's county of residence becomes an important issue when determining financial responsibility for the provision of inpatient services. This issue may be further complicated when the individual has a forensic legal status.

This section is intended to clarify the residence categories as they relate to a person in a forensic status. This clarification will provide consistency in terminology and information that is documented in the Ohio Department of Mental Health (ODMH) Patient Care System (PCS), *including the provision of the UCI number to ODMH BHOs. Boards will be required to verify patients assigned residency to them on a daily basis.*

Applicability

These guidelines are applicable to persons admitted to an ODMH Behavioral Healthcare Organization (BHO) and are tracked as forensic status.

Definitions

In accordance with Section 5122.01(S) of the Ohio Revised Code (ORC), **residence** (for financial responsibility purposes) is defined as a person's physical presence in a county with intent to remain there, except that: (1) If a person is receiving mental health services at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained his primary place of residence at the time the person entered the facility; or (2) committed pursuant to Section 2945.38, 2945.39, 2945.40, 2945.401 or 2945.402 of the ORC, residence means the county where the criminal charges were filed. The court order or journal entry should be consulted to verify the county where the charges were filed. [Except for persons civilly committed after a finding under 2945.38 (H) (4)].

The following terms are used in these guidelines to ensure consistency:

- **County of Legal Residence** - the county of the person's usual residence
- **County of Committing Court** - the county where the criminal charges were filed
- **County of Service Provision** - a county other than the home county or legal county where a person may be receiving mental health services (generally this is applicable to persons on conditional release commitment)

For purposes of these guidelines, forensic legal status includes persons admitted in the following statuses or for tracking purposes have been flagged in the PCS system as Forensic:

Section 2945.371(G)(3) and (G)(4) – Competency/Sanity Evaluation

Section 2945.38(A) – Competent – Maintain Restoration

Section 2945.38(B) - Incompetent to Stand Trial - Restoration Treatment Mandatory

Section 2945.38(H)(4) - Incompetent to Stand Trial - Unrestorable (Civil admission status)

Section 2945.39(A) - Incompetent to Stand Trial - Unrestorable - Criminal Court Jurisdiction

Section 2945.40 - Not Guilty by Reason of Insanity

Section 2945.402 - Incompetent to Stand Trial - Unrestorable - Criminal Court Jurisdiction/ Not Guilty by Reason of Insanity on Conditional Release

Section 2967.22 - Parolee/Probationer (Civil admission status)

Jail Transfers (Civil admission status)

Police Holds (Civil admission status)

Determination of County of Residence

The Alcohol, Drug Addiction and Mental Health (ADAMHS) Boards and Community Mental Health (CMH) Boards are responsible to provide services to the residents of the county that they serve. The Boards are financially responsible for inpatient services when a person is hospitalized under a civil status **and** for some persons in a forensic legal status.

When an individual is charged with a crime, they are usually under the jurisdiction of a criminal court in the county where these charges were initiated. This county becomes the county of committing court. This may or may not be their county of legal residence. The county of committing court is usually financially responsible for their services. The guidelines below further delineate the county of responsibility.

At the time of pre-hospitalization screening, the designated community mental health agency is responsible to determine the person's county of legal residence in accordance with Section 5122.01(S) of the O.R.C., and document the person's UCI number to the ODMH BHO. Within two hours of admission to an Ohio Department of Mental Health (ODMH) BHO the admission information is entered in PCS. Each board is responsible to monitor new admissions on a daily basis, and shall follow the procedures as previously outlined if a dispute occurs. Boards have 24 hours to verify residence to the BHO and document the UCI number. If it is determined that a county other than the one indicated at pre-screening is the county of legal residence, the new board shall document the UCI number to the BHO. **At admission, persons with a forensic legal status are assigned a County of Legal Residence and the County of the Committing Court shall also be documented in PCS, along with the individual's UCI number.** There may be one county, or two different Ohio counties that are entered into PCS for forensic admissions.

Guidelines for Financial Responsibility of Inpatient Services

The following guidelines should be followed to assist in clarifying financial responsibility:

1. The County of Legal Residence is financially responsible for inpatient services for persons in the following forensic categories:

2945.38(H)(4) - Incompetent to Stand Trial-Unrestorable

2967.22 - Parolee/Probationer

Jail Transfers and Police Hold

2. The County of the Committing Court is financially responsible for inpatient services for persons in the following forensic categories:

2945.38A - Competent - Maintain Restoration

2945.371(G)(3) - Sanity Evaluation

2945.371(G)(4) - Competency Evaluation

3. ODMH has the financial responsibility for individuals in the following forensic legal statuses in an ODMH hospital:

2945.38 (B) - Incompetent to Stand Trial - Restoration Treatment Mandatory

2945.40 - Not Guilty by Reason of Insanity (NGRI)

2945.39 (A) - Incompetent to Stand Trial - Unrestorable - Criminal Court Jurisdiction

2945.402/402A1 - Conditional Release (IST-U-CJ or NGRI)

Persons listed in 3), above, remain under the jurisdiction of the Criminal Court in the county of the committing court (where the charges were filed).

Persons on Conditional Release commitment who are admitted/re-admitted to an ODMH hospital are the financial responsibility of **ODMH** while in the BHO.

In some cases, an individual may have more than one criminal charge from more than one county court. These cases are worked out between the courts that are involved. Generally, the most serious charge takes precedence, but the involved courts determine this. **The BHO Legal Assurance Administrator, in conjunction with the County of Committing Courts' Forensic Monitors, will resolve this issue prior to discharge from a BHO.**

After an individual is terminated from the Criminal Court's jurisdiction they become the financial responsibility of the **County of Legal Residence** for inpatient and outpatient services.

Guidelines and Operating Principles for Outpatient Residency Determinations Among CMH/ADAS/ADAMHS Boards

Residency Guidelines

1. The purpose of these guidelines and operating principles is to clarify what is to take place, in terms of Board responsibilities and residency determinations, when clients seek services outside their service district of residence.
 - a. Nothing contained in this document should be interpreted to reduce in any way the obligation of Boards set forth in ORC Section 5122.01(S) to deal with crisis/emergency situations which occur within their service districts and to respond to essential client service needs while residency questions are being resolved.
 - b. Regardless of residency determination, nothing contained in this document should be interpreted to constrain the freedom of clients to seek services wherever they wish. Rather, it is intended to clarify which Board is to deal with such requests and under the auspices of which Board's Community Plan they are to be considered.
2. For the purposes of MACSIS, the county of assigned residency determines into which Board's service system (i.e. group and plan) an individual is to be enrolled. In special circumstances a client may live in a Board area that differs from that to which residency/enrollment has been legitimately and appropriately assigned.
3. A fundamental tenet that is to guide residency policy and its interpretation is that continuity-of-care is paramount and that responsibility to ensure this in instances of out-of-district placement or referral should rest ultimately with the "home" Board from which the client came. A Board should not be in a position to shift this responsibility by facilitating the relocation of clients to facilities or services that lie outside its service district. The "home" Board to which a client's residency is assigned should carry the following responsibilities (some of which may be delegated to another entity):
 - a. Assuring reasonable client access to the services called for in the Board's approved Community Plan in a fair and equitable manner.
 - b. Enrolling eligible persons in its benefit plans in accordance with the applicable business rules and providing for the provision and management of these benefits.
 - c. Serving as the local authority for funding, contracting, coordinating, monitoring, and evaluating services. These

responsibilities include clinical oversight and utilization review responsibilities as authorized by Chapters 340 and 5122 of the Revised Code.

- d. Providing the necessary financial resources (to the extent such resources are available to the Board).
- e. Taking the initiative to negotiate and implement workable solutions when problems involving residency arise.

4. Residency determinations are to be based upon the following:

- a. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which read as follows:

"Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residence means the county where the criminal charges were filed.

- b. For alcohol/drug clients, the definition of residency established by ODADAS, which reads as follows:

"Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

5. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, ODMH and ODADAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" Board because of a client's placement in a special residential program or facility or because of other unusual circumstances.

6. The provisions of ORC Section 5122.01(S) and the ODADAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:

- a. A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).
- b. The type of facilities encompassed includes hospitals, nursing homes, ODMH-licensed and ODADAS certified residential facilities, ODH-licensed Adult Care

Facilities, mental retardation group homes, ICF/MR'S, rest homes, drug/alcohol residential programs, crisis shelters, foster-care homes, etc..

- c. The term "mental health services" is to be construed broadly to encompass all those items contained in OAC 5122-25-02(B) and ORC Section 340.09 and the term "alcohol or other drug addiction services" shall include all those alcohol/drug services identified in OAC 3793:2-1-08 through 17.
 - d. The phrase "receiving (MH or AOD) services at a program/facility" is to be understood to mean "while on the rolls of the program/facility." It is not necessary either for the services to be provided "on the premises of the program/facility" or "by an employee of the program/facility." Likewise, it is not necessary for said services to be officially certified for the purposes of residency determination.
 - e. There is to be no "statute of limitations" on designated residency remaining with the "home" Board for persons placed in specialized residential programs/facilities that lie outside its service district.
 - f. Designated residency shall remain with the "home" Board regardless of whether it was directly involved in facilitating placement in an out-of-district specialized program/facility.
 - g. Residency shall not remain with the "home" Board in those situations where a client is placed for an indefinite period in a facility for reasons having nothing to do with mental health or alcohol/drug needs and then develops such problems subsequent to placement. However, no discharge directly from a state hospital to a facility shall cause a change in residency, regardless of the reasons for the discharge.
7. The interpretation of the provisions of ORC Section 5122.01(S) and the ODADAS definition of residency in regard to "intent to remain" shall be guided by the following:
- a. "Intent to remain" is to be interpreted to mean a person's expressed intent, as documented by completing and signing the Residency Verification Form, to remain in the county, with the exception of persons in specialized treatment facilities. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose. The Residency Verification Form should be completed when:
 - 1) The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county)
 - 2) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (ex. domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county)
 - 3) The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

- b. Boards may request from in-county, contracting providers one of the following forms of documentation that is current to assess whether a person's actions demonstrate intent to be a resident. The contract between a provider and board may dictate the form of documentation required for cases not outlined in section 7.a. above.
 1. mailing address
 2. voting
 3. car registration
 4. job or other vocational efforts
 5. payment of taxes
 6. location of family
 7. general conduct.
 8. signed Residency Verification Form
 - Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.
 - Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-à-vis residency.
 - For out-of-county, non-contracting providers, a signed Residency Verification Form shall suffice as proof of residency.
8. Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a CSB, ODYS, etc.), residency should remain with the "home" Board of the county where the court that ruled maintains jurisdiction. Completion and signing of the Residency Verification Form shall provide residency documentation for children.
 - a. This guideline is not intended to resolve boundary issues between the responsibilities of Boards versus those of CSB's, juvenile courts, DYS, etc.. Rather, it is intended to clarify that it is the responsibility of the "home" Board to work through such matters for its clients.
 - b. Persons with handicapping conditions who consequently may remain in the custody of a CSB, etc., through their 21st year shall be considered to be children for the purposes of these guidelines.
9. The interpretation of these residency provisions for children is to be guided by the provisions of ORC Sections 3313.64(A)(1 and 4), 3313.64 (C)(2), and 2151.35, which deal with the determination of local responsibility within the educational system.

10. For clients committed pursuant to ORC Sections 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residency shall remain with the Board of the service district in which the charges were filed only for as long as the client remains in a forensic status. If and when the client's status reverts to a civil commitment, at that point the client's residency shall be changed to that to which it would be for non-forensic clients (i.e. the "home" Board from which the client originally came). For those clients who may be in a non-hospital setting when their commitment status changes, residency should be determined by type of facility and/or intent, depending upon the circumstances. When residency shifts because of a change in forensic status, the Board from which residency is being shifted is to give timely notice to the new Board of residency.
11. Where special circumstances, such as result from unusual geographic boundaries, create situations where the applicability of the residency criteria in the law may be especially problematic, the Boards involved may negotiate a "Memorandum of Understanding" as to how various issues will be addressed, rather than repeatedly disputing individual cases.
12. A Board (directly or through its contract agencies) may receive requests for services from a client whose residency rests with the Board of another service district (with this encompassing clients involved in emergencies while away from home, clients wishing to travel to receive non-emergency services from a provider in another district, and clients placed in a specialized residential facility who seek additional services beyond that which the facility itself may provide). Such requests for services from non-residents should be dealt with as follows:
 - a. Emergency/crisis situations are to be addressed by the Board and/or designated agency where the crisis occurs, regardless of the client's official residency assignment.
 1. To the extent that commitment/probate matters may be involved in addressing the crisis, the Boards involved shall be guided by the "Statewide Contract for Services for Persons Receiving Treatment through CMHB's" negotiated in 1989 in response to the passage of the Mental Health Act of 1988.
 2. For mental health, non-Medicaid services, the board providing the service is responsible for crisis intervention and pre-hospitalization services up to three days.

For ODADAS, non-Medicaid services out of county/ emergency/ clinically appropriate services are the Level I services (Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Screening Analysis, Medical/Somatic, Methadone Administration and Intensive Outpatient services) plus Level III and Level IV Detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend beyond three days, the home board must approve the out-of-county placement. It is essential collaborative efforts be made between providers and Boards to establish arrangements for a client's continued care.

3. When an enrollee of a Board receives crisis services [as defined above in paragraph (2)] outside his/her service district and under the auspices of another Board's service system, financial responsibility for

these crisis services shall be borne by the Board in which the client is enrolled. The rate for said services shall be that contained in the contract of the local Board under whose auspices the services are being provided.

4. A Board which is providing crisis/emergency services for an individual who is enrolled in another Board's plan shall contact that other Board (or its designee) within one business day, to notify it that one of its members is involved in a crisis situation and to consult on the disposition of the case.
 - a. The Board in which a client is enrolled shall have no financial responsibility for the provision of out-of-district crisis services beyond three days without its concurrence. In the event it is anticipated that the three-day limit shall be exceeded, the Board/agency involved in the provision of crisis services to an out-of-district party shall be responsible for contacting the Board of residency/enrollment to establish appropriate arrangements for payment or to provide for the orderly transfer of the client to a provider selected by the home Board.
 - b. Services other than emergency/crisis services and Medicaid-billable services should remain the sole responsibility of the "home" Board of residency, with this responsibility understood to encompass the items listed in section #2 of this document.
 - c. The Chief Clinical Officer (or designee) of the "home" Board should be responsible for determining what services may be clinically necessary and appropriate for an individual seeking services outside of his/her "home" district. The "home" Board should bear ultimate responsibility for overseeing and supporting the provision of appropriate out-of-district services (to the extent they are approved as being consistent with the Board's Community Plan and sufficient financial resources are available).
 - d. For non-Medicaid services, a Board may have "preferred providers" (i.e. its contract agencies) and expect residents seeking Board-subsidized services to use these organizations.
 - e. Non-emergency services may be provided to out-of-district clients by either the "home" Board of residence or the Board from which the client is seeking services. However, no Board should be expected or assumed to provide ongoing, non-emergency services to out-of-district clients without its explicit consent and without a mutually agreeable reimbursement mechanism having been negotiated. All Boards should adopt official policies and procedures which layout how it will respond to requests of its residents who seek services outside the Board's service district.
 - f. Anytime an SMD client is placed in an out-of-district residential facility with the involvement of the public community mental

health system, the "home" Board should notify the Board where the facility is located and work out matters of service coordination and continuity-of-care.

- g. Contract agencies are free to serve whomever they wish with funds other than those provided pursuant to a contract with a Board.
13. A person incarcerated in an out-of district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.
14. Residency disputes are to be addressed as follows:
- a. Ultimate responsibility for resolving residency disputes shall rest with ODMH and ODADAS, whose decisions shall be binding.
 - b. ODMH and ODADAS shall officially adopt and distribute these "Guidelines and Operating Principles" (along with any subsequent modifications), with the explicit understanding that they are to be followed in the determination of residency.
 - c. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.
 - d. As the initial step in the formal dispute resolution process, the Board which believes that an individual's residency has been inappropriately determined is to contact the Board it believes is the proper Board to which residency should be assigned. This is to be done in writing and, unless there are extenuating circumstances, is to take place within ten working days of the time a Board first becomes aware that a residency assignment may need to be questioned.
 - e. After receipt of the written statement initiating the residency dispute process, the two Boards shall have five additional working days to agree upon the appropriate residency designation. If the matter remains unresolved, either Board may refer the matter to ODMH or ODADAS (depending upon the circumstances) for final resolution. This shall be done in writing and shall occur immediately upon expiration of the five working days during which the Boards are to attempt to resolve the matter between them. The Director of ODMH/ODADAS (or his/her designee) shall make a final determination about residency within ten additional working days, during which time the Boards involved in the dispute and other relevant parties (including, where appropriate, the client) are to be contacted. A written determination, including the rationale for the decision, is to be provided to both Boards.
15. A public record (with client names deleted) of precedents for how residency disputes are resolved by ODMH/ODADAS is to be maintained, so as to serve as a guide for dealing with subsequent disputes.

16. While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the Board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which Board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a Board other than the Board that paid for the services is the appropriate Board of residence then the Board that paid for the cost of service will invoice the Board of residence. The Board of residence will be expected to pay the Board of service within a reasonable amount of time.

[For Medicaid purposes only, while the residency dispute process is taking place, the automatic contracting and payment of Medicaid reimbursable services is not to be interrupted or delayed in any way. This is to say that no changes are to be made to the MACSIS "plan" the client is enrolled in, Medicaid reimbursable services are to be continued to be provided and paid for and, if necessary, the "Secondary" Medicaid Contract is to be established within the 30-day limit. For MACSIS purposes, ODMH/ODADAS reserve the right to take any action deemed necessary to assure this process is strictly adhered to.]

17. No Board is to alter an individual's residency/plan assignment within MACSIS without the explicit approval of the other affected Board or a formal ODMH/ODADAS resolution of a residency dispute. (Normal practice should be for the receiving Board to effect a residency change in MACSIS.)
18. Nothing in this document should be interpreted as precluding two Boards from effecting a transfer of residency responsibilities when they mutually determine this to be in the best interest of a client.
 - a. These guidelines deal only with inter-Board residency issues and are not intended to address situations where individuals may be placed or seek services across state lines. It is felt that the issues involved are enough different to warrant separate consideration.

Appendices A through E

A: Guidelines to be used in determining the county of residency for College Students, Homeless Clients and Migrant Workers.

Please note: these guidelines address county of residency determinations for MACSIS enrollment/ plan/panel assignment and not State Hospital county of residency issues.

1. College Student Guideline

As referenced in "The Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards" (Page4, Section 8), the residency for children is to be determined by the residency of the parent(s)/or guardian(s) and should change when the parent(s)/guardian(s) move (even when the move occurs in the middle of a hospitalization or residential placement).

The primary question to use in determining whether or not this guideline is applicable is: "Is the student an IRS Tax Dependent?" If the student is, then the board area in which the parent(s)/guardian(s) reside is the child's county of residence. The student is to be enrolled in one of that county's plan(s)/panel(s).

If the student is not considered an IRS Tax Dependent, then the following is to be taken into consideration for county of residency determination:

Is the student emancipated?
Is this a graduate level student?
Does this student have dependent children?

Students who fall within these criteria should have further screening to determine actual county of residency. Please reference the Guidelines and Operating Principles for Residency Determinations among CMH/ADAS/ADAMHS Boards (Page 2, Section 4). Has the client/student established residency or expressed the intent to remain? If the client has, then the Board must enroll that student as a resident of their county. If it is an out of state college student, enrollment criteria should be developed and implemented by the local Board. These students should be enrolled using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field.

2. Homeless Client Guideline

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Example:

The client was originally enrolled in a plan/panel of the Franklin County ADAMHS Board. This client subsequently presents in Montgomery county for services and claims to be homeless (please note that this client can claim an address of homeless or an address of a homeless shelter). The Montgomery County ADAMHS Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. If this client continues their journey and presents for services in Butler county two months later and again claims to be homeless, the Butler County Boards should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. Please note, it is intended for MACSIS to track this type of client to assist in identifying such populations and their need for continuity of care.

How to process enrollments/transfers in MACSIS:

- a. Client not previously enrolled. Board area in which the client presents as homeless should enroll immediately for benefits. Note: A client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

- b. Client previously enrolled. If the client is already enrolled in another Board's plan/panel, then the Board in which client has presented for services and stated homelessness MUST immediately transfer the client into one of their plan/panel combinations. As previously noted above, a client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

3. Migrant Worker Guideline

The following guideline is applicable to Legal Migrant Workers. (Illegal Migrant workers are still under discussion, however, it was noted that boards should be utilizing the "Out of County Service Matrix" when dealing with these clients.)

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Please reference the "Homeless Client Guideline" above.

4. Out of State Client Guideline

How to handle the enrollments within MACSIS:

- a. If the client has a valid Ohio Medicaid card, then the Board in which the client has presented for service should enroll the client in one of their plan/panel combinations or if the client has previously been enrolled, immediately transfer the client to one of their plan/panel combinations.
- b. If the client does NOT have a valid Ohio Medicaid card, then the Board could exercise their local option to enroll these clients for service. (Please reference the enrollment guideline for out of state college students.)

B. Criminal Justice System and Residence Determinations

As part of the Multi-Agency Community Services Information System (MACSIS) implementation by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH), many questions have arisen concerning how to determine the "county of residence" for a client who has recently been under the auspices of the Ohio Department of Rehabilitation and Correction (ODRC) system and is in need of alcohol and other drug or mental health services.

A workgroup, consisting of representatives from ODADAS, ODMH, ODRC, and Alcohol and Drug Addiction Services (ADAS) Boards, Community Mental Health Services (CMHS) Boards, Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and in conjunction with provider input, believes the "Guidelines and Operating Principles for Residency Determination among CMH/ADAS/ADAMHS Boards" document is adequate for determining county of residence in this situation. Former offenders should be treated, for residence determination purposes, in the same manner as any other individual in the State of Ohio. Primacy for determining county of residence shall be upon the individual's statement (i.e., expressed intent to remain)

and/or upon the individual's county of residence prior to becoming a charge of the ODRC system.

The applicable section of the residency determination guidelines can be found on page 3, paragraphs 6. a. and b. ODRC will bear the financial responsibility for necessary drug and alcohol and/or mental health services provided to Transitional Control inmates housed in halfway houses contracted with ODRC. When a person transitions from an inmate status to a non-inmate status, eligibility for and the financial responsibility for alcohol and other drug and/or mental health services should be determined as it would be for any other Ohioan. The attached documents, including an inmate versus non-inmate status matrix developed by ODRC and shared and reviewed by the workgroup, should be used in determining when an individual's services are the responsibility of ODRC and when the individual's services become the responsibility of the community alcohol and drug and/or mental health system.

Inmate Status	Non-Inmate Status
Halfway House Population: Transitional Control Offender (ODRC Jurisdiction) Prison (ODRC Jurisdiction)	Halfway House Population: Parole/Post-Release Control/Probation/Community Control
CBCF (County/Court Jurisdiction) Jail (County/Sheriff Jurisdiction)	Non-Halfway House Population: Parole/Post Release Control

Jails and CBCF's (Community-Based Correctional Facilities)

- A person in a jail is considered an inmate.
- ODRC does not provide MH or AoD funding for jails but does set standards by which jails are to provide substance abuse and/or mental health treatment services.
- A person in a CBCF is considered an inmate of a correctional institution and is under the jurisdiction of a common pleas court.
- Either of these persons is still a resident of his/her home county.
- In many communities the local ADAS/ADAMHS/CMHS Board has traditionally, through a voluntary collaborative arrangement with the local Judicial Corrections Board, made arrangements for the CBCF to utilize local AoD and MH agencies for the provision of needed services.

- These scenarios are covered by section 11 of the "Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards."
- A person incarcerated in an out-of-district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

Halfway House

ODRC currently contracts with 24 halfway houses throughout the state. All of these facilities house individuals who are considered non-inmates, with the exception of those facilities that serve Transitional Control offenders. Transitional Control (or furlough) clients are considered inmates and their services are the responsibility of ODRC. At which time an offender is no longer under Transitional Control status and is transferred to another status, such as parole or post-release control, and expresses an "intent to remain" in the county, the offender may be referred to community agencies and is eligible for services as any other resident of that county.

C. Normal Out of County Enrollment Process

Step 1 Provider determines client's county of residence.

It is the Provider's responsibility to obtain sufficient documentation to determine the client's county (Board) of residence. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence.

Step 2 Provider completes enrollment form, after client has signed release and authorization to bill.

The Provider is responsible for discussing the Notice of Enrollment with the client and obtaining all releases and disclosures per the confidentiality guidelines.

Step 3 Provider faxes form to enrollment center for the board where the client resides.

Once the Provider has determined the residency of the client, the Provider must fax the enrollment form to that Board's enrollment center to begin the enrollment process. The Provider must indicate on the enrollment form that releases have been obtained for that specific Board area.

Step 4 Board enrolls the client or works with the provider to clarify questions.

Upon receipt of an enrollment form from a Provider that is treating a client who is a resident of that Board area, the Board's enrollment center should look up the client, enroll the client if not already in MACSIS, and then return to the

provider the client's UCI, plan assignment and rider information. If there are points of clarification, the Board is responsible for making contact with the Provider to resolve any questions.

Step 5 Board faxes back UCI to provider.

It is recommended that no more than 5 business days (1) should separate the faxing of the enrollment form from the provider to the board and the receipt of the UCI by the provider. The provider will then use the UCI to bill for services. Medicaid clients receiving Medicaid certified services will be paid and non-Medicaid clients and non-Medicaid services will be subject to the Out of County guidelines.

D. Disputed Out of County Enrollment Process (for Providers)

Step 1 Provider follows Normal Enrollment Process.

In all cases, the Provider should follow the process established for a normal out of county enrollment. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence. Examples of documentation that can be used to establish a client's residency include:

- Driver License
- State ID Card
- Lease agreement
- Adoption or custody papers
- Statement from Client (Signed and Witnessed) Indicating Residency

Step 2 Board of Residency Refuses to Enroll an Out of County Client

If the Board (where the Provider determines the client resides) refuses to enroll the client or fails to provide a UCI within ten business days, the provider should contact the MACSIS Support line.

Step 3 MACSIS Support Line Enrolls Client

The Provider will provide the MACSIS Support line with copies of the enrollment form and all supporting information that was provided to the Board. As soon as the proper documentation has been received, the MACSIS Support Line staff will send an email to the affected board and wait 1 working day before doing the enrollment. This is to provide time for the affected board to become aware of the issue. (2)

The MACSIS Support Line staff will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Line will follow the rules as outlined in the Summary Matrix that was included in the December 7, 1999 joint memo from Carolyn Givens and Rick Tully titled: Out-of-County MACSIS Enrollment. A copy of the body of that memo will be included as an attachment to this Guideline.

Note: Providers should be aware that non-Medicaid clients that are not in Crisis WILL NOT be enrolled per the Summary Matrix included in this notice.

The MACSIS Support line Staff will then electronically notify both the Board where the client has been enrolled and the provider that is treating the client, with the enrollment information.

Step 4 Residency Dispute Claim Submitted. If the board where the client is enrolled disputes the residency determination and action taken by the MACSIS Support Line, the Board may file a formal residency dispute following the established RDD Guidelines.

(1) The expectation remains that the majority of enrollments will occur within two (2) to five (5) days. It is understood, however, that exceptional circumstances will occur, particularly with out-of-county enrollments. In no event, however, should any enrollment, in-county or out-of-county, take longer than ten (10) days.

(2) The MACSIS Support Line is not responsible for settling residency disputes and therefore, should not be expected to respond to board disputes which might result from the e-mail notification. They will continue, as outlined in this procedure (i.e., enrolling the client) and the disputing board must then file the appropriate dispute as noted in the RDD guidelines.

E. Clarification of requirements for out-of-county MACSIS enrollment

Mental Health Services

1. Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.

In these circumstances such persons must be enrolled with the appropriate Board residence of pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

2. Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in emergency situations.

In these circumstances, such persons must be enrolled with the appropriate Board of residence pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying non-Medicaid claims for Crisis Intervention and Pre-hospitalization Screening services in emergency situations for a period up to 72 hours.

3. Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in non-emergency situations.

In these circumstances the provider organization is not required to enroll such persons. However, the provider organization should refer such persons to the Enrollment Center (a complete listing will be posted on the MACSIS Website) for the person's Board of residence in order to be linked with the appropriate provider organization. The out-of-county provider organization should offer the person assistance in contacting the Enrollment Center for the person's Board of residence. Such assistance in referral will better ensure appropriate continuity of care.

Alcohol and Drug Addiction Services

Medicaid

1. Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.

In these circumstances such persons must be enrolled with the appropriate Board residence of pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

Non-Medicaid

1. ODADAS recognizes non-Medicaid services, out-of-county services, emergency services or clinically appropriate services as:

- Level I Services (Assessment, Individual counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Screening Analysis, Medical/Somatic, Methadone Administration and Intensive Outpatient Services, plus)
- Levels III and IV Detoxification Services

Non-Medicaid clients who present for services out-of-county are eligible for Board funding under the same considerations as if the clients presented for services in their home county. Level I services and Levels III and IV detoxification services may be provided for three days or until linkage to treatment is established in the "home county." If out-of-county treatment is to extend beyond three days, the home board must approve the out-of-county placement. It is essential that collaborative efforts occur between providers and Boards to establish arrangements for a client's continued care.

[Out-of-County MACSIS Enrollment Summary Matrix](#)

Circumstances	MH	AOD
Medicaid eligible person - emergency or non-emergency	Enrollment: Must enroll. Services: Any Medicaid covered service.	Enrollment: Must enroll. Services: Any ODADAS Medicaid covered service.
Non-Medicaid eligible person - emergency	Enrollment: Must enroll. Services: Pre-hospitalization and Crisis Intervention for up to three days (72 hours).	Enrollment: Must enroll Services: Level I Services:(assessment, individual counseling, group counseling, crisis intervention, case management, alcohol/drug screening analysis, medical /somatic, intensive outpatient and methadone administration) plus Levels III and IV detoxification services for three days or until linkage to treatment is established in the "home county".
Non-Medicaid eligible person - non-emergency	Enrollment: Not required. Services: Not required to pay for services.	Enrollment: Must enroll Services: Level I services plus Levels III and IV detoxification services for three days or until linkage to treatment is established in the "home county"

Appendix U

OHIO DEPARTMENT OF MENTAL HEALTH

FORENSIC TRACKING AND MONITORING SYSTEM GUIDELINE

A. PURPOSE

This guideline establishes procedures for reporting data regarding persons with a specific forensic legal status as defined below and who are on Conditional Release commitment under the jurisdiction of the Criminal Court.

B. APPLICATION

This guideline applies to all Alcohol, Drug Addiction and Mental Health (ADAMH) and Community Mental Health (CMH) Boards, the Board appointed Forensic Monitors and their designee(s).

C. SPECIFIC FORENSIC LEGAL STATUS DEFINITIONS

“Forensic Legal Status” for the purpose of this guideline refers to persons found:

1. ORC 2945.39 (A)(2) Incompetent to Stand Trial- Unrestorable - Criminal Court Jurisdiction (IST-U-CJ) and placed on Conditional Release pursuant to ORC 2945.401 and 2945.402, and
2. ORC 2945.40 Not Guilty by Reason of Insanity and placed on Conditional Release pursuant to ORC 2945.401 and 2945.402.

D. PROCEDURES

1. Reporting data on persons with a specific forensic legal status, as defined above, is the responsibility of the ADAMHS or CMH Board. The Board may designate the Forensic Monitor or an appropriately-trained person to complete this duty.
2. Data shall be reported quarterly on either a paper document (DMH-FORS-011) or by a suitable electronic format determined by the Office of Forensic Services. The data is due in the Office of Forensic Services no later than 45 days following the end of the Reporting Period.
3. Data shall be first reported for the Reporting Period in which the patient is initially placed on Conditional Release. The data shall continue to be reported on a quarterly basis until the patient’s Conditional Release is terminated.
4. After the initial report is made, only those data elements which have changed during subsequent Reporting Periods will need to be provided. Refer to the instructional sheet which accompanies the data tracking form for specific procedures regarding the reporting of data.

(These guidelines were originally issued by Dr. Michael Hogan to the ADAMHS and CMH Boards on 8-29-97).

Appendix V



Department of
Mental Health

John R. Kasich, Governor
Tracy J. Plouck, Director

TO: Hospital CEOs
Hospital CCOs

FROM: Robert Short
Deputy Director of Hospital Services

SUBJECT: Victim Notification Requirements

DATE: October 14, 2011

Just a reminder that Ohio law (SB 186; 1994) requires notification of victims or a victim's representative at time of discharge from our Hospitals. The statutes impose broad duties upon law enforcement, prosecutors, court systems, and custodial agencies with regard to the notification of crime victims or the victim's representative and with regard to victim's rights.

The statute clearly defines custodial agencies as inclusive of Department of Mental Health facilities, and describes the hospitals' responsibilities in notifying victims or a victim's representative.

Specific hospitals' responsibilities are enumerated in Revised Code Section [2930.16](#) (C) (4-6):

Upon the victim's request, the custodial agency of a defendant shall give the victim of the defendant any of the following notices that are applicable:

Prompt notice to the victim of the defendant's escape from a facility in which he was incarcerated or the defendant's absence without leave from a mental health facility or from other custody and of the capture of the defendant after an escape or absence;

Notice to the victim of the defendant's death while in custody;

Notice to the victim of the defendant's release from confinement and the conditions of the release.

Therefore please assure that the following steps are taken in accordance with this statute:

1. If any hospital is notified by the prosecutor's office that a victim or victim representative has requested notification of any activities contained in Revised Code Section 2930.16 (4-6) the LAA shall note the patient's

name, and the name, address and phone number of the victim or victim representative.

2. If a victim or victim representative contacts the hospital directly, the victim or victim representative shall be informed that the hospital shall first contact the prosecutor's office to verify the victim's or victim representative's status.
3. The hospital shall have procedures that assure the victim or victim representative will be notified if the identified patient becomes AWOL, returns from AWOL, dies while in custody, or is otherwise released from the hospital. The hospital procedures shall include methods which include the verification of this notification.

If the patient becomes AWOL, the hospital staff shall telephone the victim or victim representative to notify them of the AWOL. This same notification shall also occur when the patient is returned from AWOL. These notifications shall occur within 24 hours of the AWOL/return from AWOL occurrence. Documentation must be maintained on all successful and unsuccessful attempts at contacting the victim or victim representatives as requested.

Please note that the statute also requires that the victim or victim representative maintain their current address and telephone number with the identified hospital. In cases of a patient's death, release, AWOL, and return from AWOL, the hospital shall notify the victim or victim representative by telephone and follow up with Certified Mail notification.

4. The hospital shall also have procedures which ensure that the defendant has received information from the hospital Client Advocate regarding the statute concerning victims or victim representative's right to notification of the above circumstances. The hospital shall ensure that the defendant does not receive any additional information about the victim or victim representative but only information regarding the victim notification process.

Each hospital shall record statistics on the number of requests made for notification and the number of notifications made for future analysis.

cc: Max McGee, M.D., Acting Medical Director
Marc Baumgarten, Office of Legal Services
Robert Baker, Office of Forensic Services
Tereasa Moorman Jamison, Office of Forensic Services
Carrol A. Hernandez, Assistant Deputy Director, PPD
Deborah Nixon-Hughes, Deputy Director, PPD

Establishing mental health as a cornerstone of overall health

30 East Broad Street	614 466-2596
Columbus, Ohio 43215	614 752-9696 TTY
mentalhealth.ohio.gov	614 752-9453 Fax

Appendix W

Ohio Department of Mental Health

DOCUMENT NUMBER: 5122-3-05

TYPE OF DOCUMENT: Rule

AUTHORITY SOURCE: Sections 5119.01 and 2152.13 ORC

DOCUMENT TITLE: Competency to stand trial assessment and restoration services for serious youthful offenders (SYOs)

APPLICABILITY STATEMENT: Regional Psychiatric Hospitals (RPHs)

EXCEPTIONS IF APPLICABLE: None

EFFECTIVE DATE: 1-24-2011

REPLACES: 1-2-2002 (Emer.); 5-8-2007 (Reviewed w/no changes)

DIRECTED TO: RPHs

DISTRIBUTED BY: Office of Medical Director

5122-3-05 Competency to stand trial assessment and restoration services for serious youthful offenders (SYOs)

(A) Purpose and background

- (1) The purpose of this rule shall be to establish guidelines for competency assessment and restoration treatment of serious youthful offenders (SYOs). Pursuant to section 2152.13 of the Revised Code, effective January 1, 2002, SYOs are afforded all the rights a person who is criminally prosecuted would have if the crime were committed by an adult. This includes the right to be competent to stand trial and utilization of the procedure outlined in chapter 2945. of the Revised Code, related to competency to stand trial.
- (2) Placement/treatment of young children on adult units raises fundamental concerns about the safety and effectiveness of treatment, since ODMH only operates adult inpatient facilities. Treatment of children/adolescents must consider the child's developmental needs and mental status in order to be safe and effective. This rule establishes separate and distinct procedures and guidelines for competency assessment and restoration of children/adolescents. This rule will provide procedures for handling potential referrals from the juvenile courts in Ohio to ODMH facilities. Substantial precedent and common sense support the separation of children from adults in inpatient settings. Prior to the closure of ODMH children's hospitals, in accordance with section 5119.03 of the Revised Code, the department operated separate institutions for children and adults. ODMH private psychiatric hospital licensure rules require that children and adult beds be separate, except for

certain emergency admissions of brief periods (forty-eight to seventy-two hours) for older adolescents, aged fifteen through seventeen.

Under this rule, seventeen year olds may be admitted and treated in an adult bed if the person is functioning as an adult in such areas as employment, family, or marriage, or if the diagnosis or problem is such that treatment is warranted in an adult bed.

National professional guidelines clearly recognize that children and adolescents younger than fourteen should be admitted only to programs that are designed for youth and physically distinct from adult psychiatric inpatient programs. Adolescents sixteen and older may be admitted to adult units for valid clinical reasons, but should be treated in a program designed to meet their specific needs. Children and adolescent programs should address the youth's developmental needs including those for education and age-appropriate social interaction.

(B) Definitions

The following definition shall apply to this rule in addition to or in place of those appearing in rule 5122-1-01 of the Administrative Code:

"Serious youthful offender" and "SYO" have the same meaning as in division (X) of section 2152.02 of the Revised Code, i.e. a person who is eligible for a mandatory SYO or discretionary SYO, but who is not transferred to adult court under a mandatory or discretionary transfer.

(C) General guidelines

- (1) Young children (under age fourteen years) and younger adolescents (ages fourteen to fifteen) should not be placed in an ODMH RPH because adult facilities are not designed or staffed to provide age-appropriate services for youth. Additionally, because interaction with adult patients on these units may be problematic, these children should be placed in an age-appropriate inpatient psychiatric unit for children or a community residential treatment facility that would specifically meet their individual needs. Older immature adolescents and those not medically cleared for admission to an adult facility should also be treated in these types of settings
- (2) Older adolescents (ages sixteen to seventeen) and some younger adolescents (ages fourteen to fifteen) in limited exceptional cases, may be admitted to adult units for valid clinical reasons but should be treated in an individualized program designed to meet their specific needs.

(D) Procedures for admission of adolescents to ODMH RPH inpatient units

- (1) Prior to such admissions for competency restoration services, the RPH chief clinical officer shall assure the following:
 - (a) The child must be medically assessed as appropriate for admission to an adult inpatient unit by a board eligible or board certified child psychiatrist with documented specialized training and experience in working with adolescents and their families in an inpatient treatment program;
 - (b) Other available less restrictive treatment resources (e.g., residential treatment, intensive outpatient), must have been considered and determined to not be

available or not appropriate to meet the youth's mental health and safety needs;
and

- (c) An individual plan of care must be developed by a child/adolescent psychiatrist or in consultation with a child/adolescent psychiatrist to meet the adolescent's restoration to competency needs including the developmental, educational, safety and environmental needs.

(E) Guidelines for adolescent competency to stand trial restoration treatment services provided in the RPH

- (1) Treatment for the adolescent should be supervised by a child/adolescent psychiatrist or in consultation with a child/adolescent psychiatrist;
- (2) All relevant components of the competency to stand trial restoration service are to be adjusted to meet the adolescent's developmental, educational, safety, and environmental needs;
- (3) Upon admission, an objective competency assessment should be performed. Standardized competency assessment tools may be utilized;
- (4) Multi-modal, experiential competency restoration educational experiences, (e.g., discussions, reading, video, role playing or mock trial), may be utilized;
- (5) An educational component should be included regarding the criminal charges, severity of charges, sentencing, pleas, plea bargaining, roles of the courtroom personnel, adversarial nature of the trial process and evaluating evidence;
- (6) Periodic reassessment of competency should be made regarding the adolescent's progress toward restoration to competence; and
- (7) Medication treatment may be needed in order for restoration to competence to occur.

Effective:	01/24/2011
Promulgated Under:	111.15
Statutory Authority:	5119.01
Rule Amplifies:	2152.13
Prior Effective Dates:	1-2-2002 (Emer.)

Appendix X



Ohio Department of Mental Retardation and Developmental Disabilities

Bob Taft, Governor

Kenneth W. Ritchey, Director



TO: Superintendents of County Boards of MRDD

FROM: Kimberly C. Anderson, Deputy Director
Division of Legal and MUI Services

DATE: March 28, 2006

RE: Community Forensic Monitoring Program

Community Forensic Monitoring Program

Introduction

The purpose of this notice is to inform you of Ohio's Forensic Monitoring Program and how it affects individuals with MR/DD when they are subject to its requirements.

Conditional Release

Section 2945.37 of the Ohio Revised Code creates the commitment status of Conditional Release for persons who are found incompetent to stand trial under criminal jurisdiction (IST-U-CJ) or not guilty by reason of insanity (NGRI). A person on Conditional Release lives and receives treatment in the community. The period of time a person receives treatment cannot exceed the maximum prison term or term of imprisonment the person could have received for the offense. At any time, the trial court may revoke the person's conditional release and order the rehospitalization or reinstitutionalization of the person.

Legal and MUI Services, 1810 Sullivant Avenue, Columbus, Ohio 43223-1239
Voice: 614.644-7342 Fax: 614.752-8551 Website: <http://www.state.oh.us/dmr>
The State of Ohio is an Equal Opportunity Employer and Provider of Services
To report Abuse/Neglect/MUIs call the Hotline: 1-866-313-MRDD (6733)

Section 2945.402 of the Ohio Revised Code is the statute on Conditional Release and it:

1. Authorizes the court to set conditions on the release with respect to the treatment, evaluation, counseling, or control of the person that the court considers necessary to protect the public safety and welfare of the person;
2. Allows the court to revoke a person's conditional release and order rehospitalization or reinstitutionalization any time the conditions of release have not been satisfied; and,
3. Requires that the person assigned to monitor a person on conditional release to immediately notify the trial court on learning that the person has violated the terms of the conditional release.

Overview of the Forensic Monitoring Program

The position of Forensic Monitor was formally created in 1996 as a result of House Bill 152 and become further defined with the enactment of Senate Bill 285. Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board and Community Mental Health (CMH) Board in Ohio is responsible to ensure that a Forensic Monitor is providing certain services for their board area. The Forensic Monitor may be employed by one Board or a consortium of Boards, by a community mental health agency, by a Community Forensic Center, or by a Community Support Network (CSN).

Section 5119.57 of the Ohio Revised Code requires that a coordinated system be developed to track and monitor persons who are NGRI and IST-U-CJ on conditional release in the community. This system is called the Forensic Tracking and Monitoring System (FTMS).

The Forensic Monitor/designee monitors individuals who have been charged with felony or misdemeanor offenses through Common Pleas and Municipal Court systems who have been found NGRI and/or found to be IST-U-CJ on Conditional Release commitment. The Forensic Monitor or designee also serves as a forensic resource and works in collaboration with others, to educate, train, consult, liaison service, collect data and compile required reports.

The Forensic Monitor or designee is typically involved with an individual prior to the person being released into the community. The monitor/designee participates in the development of the conditional release plan with the client, treatment team, County Board of MR/DD, MR/DD service providers, and the community mental health service provider as indicated. The exception to this occurs when an individual is released directly from the court to conditional release.

The Forensic Monitor or designee maintains regular contact with the community mental health providers, County Boards of MR/DD, and MR/DD service providers to support good coordination with the court system to monitor the person's progress, and to ensure that the community risk assessment instrument is being completed and to reduce the likelihood of re-offending through coordinated treatment. The monitor/designee also ensures that the court is informed about the individual's status and that all required reports are sent to the court.

Forensic Monitor/Designee Duties

1. The Forensic Monitor or designee participates with both BHO (Behavioral Healthcare Organization, i.e. state psychiatric hospital) or (the Developmental Centers), County Boards of MR/DD, MR/DD service providers, and community treatment providers in planning and coordinating services for persons found NGRI or IST-U-CJ.

Required duties:

- a. Interacts with the BHO Legal Assurance Administrator (LAA) regarding case status.
- b. Serves as liaison between the Criminal Justice System, the LAA and other BHO staff, and community treatment providers.
- c. Meets with community provider treatment teams and/or case managers to develop and implement the person's conditions of release.
- d. Monitors treatment and/or habilitation provided to the person by the service provider in accordance with the conditional release plan and the orders of the court.
- e. Involvement in the development of the conditional release plan, which includes participation with treatment staff in the development of the conditional release plan prior to discharge.
- f. Monitors reports of the person's criminal activity.

Optional duties (*include but are not limited to*):

- g. Maintains regular direct contact with the person while in a community setting.
- h. Interacts with the BHO Forensic Review Team or Developmental Center staff regarding conditional release readiness.
- i. Makes recommendations for treatment to assist in the development of conditional release plans.

2. The Forensic Monitor or designee shall interact with the Criminal Court.

Required duties:

- a. Attends hearings following a conditional release commitment.
- b. Reports compliance with conditional release plans as required by the court.

- c. Immediately reports to the court any violations of the terms of conditional release or deterioration in the individual's mental status.
- d. Initiates or participates in legal and/or administrative procedures if necessary to facilitate hospitalization or incarceration of the person who is NGRI or IST-U-CJ on conditional release.
- e. Ensures that required reports for persons in the community are submitted to the court.
- f. Reports information regarding court hearing outcomes to treatment providers and, when appropriate, notifying the BHO Legal Assurance Administrator.
- g. For those persons found NGRI or IST-U-CJ and released directly to the community from the court, develops a mechanism to identify these persons, and works with the court and treatment providers to develop and implement a conditional release plan.

Optional duties:

- h. Provide advice and consultation to the court about required hearings and other time lines as requested by the court.

3. The Forensic Monitor or designee shall work with the agencies responsible for developing community services for persons found NGRI or IST-U-CJ.

Required duties:

- a. Notifying the agency of major unusual incidents and violations of the conditional release terms as determined by the agency.
- b. Preparing statistical or narrative reports as required by the MH Board.
- c. In conjunction with MH Board staff, assisting in out-of-county service planning, including monitoring responsibility for those services.
- d. Providing training to MH Board members and staff on forensic issues.
- e. Consulting with the MH Board on forensic policy and procedure development and implementation.
- f. Working with the MH Board and others as needed to develop and implement effective community risk management policies and procedures for persons on conditional release.

4. The Forensic Monitor or designee shall cooperate with the Ohio Department of Mental Health.

Required duties:

Assisting in the ongoing implementation of the Forensic Tracking and Monitoring System (FTMS).

- a. Assisting in the ongoing implementation of the Forensic Tracking and Monitoring System (FTMS).
- b. Sending required quarterly FTMS reports to ODMH.
- c. Attending statewide Community Forensic Monitor meetings.
- d. Participating on subgroups to further the development of the statewide Forensic Monitor Program, including making recommendations on policy, procedure and guidelines as necessary.

Because individuals with MR/DD who are on Conditional Release are receiving services from County Boards of MR/DD, it is imperative that County Boards of MR/DD provide information to and work with the Forensic Monitor/designee. Therefore, if an individual on conditional status who receives services by the board has left the county; has been arrested or charged with a criminal offense; or is otherwise violating his conditional release plan; or is engaging in conduct that is dangerous to himself/herself or others, the county board is to notify the Forensic Monitor/designee.

A more in depth description of the Ohio Forensic Monitoring Program is found in the Forensic Manual, which is published by the Ohio Department of Mental Health. To obtain a copy, please contact Sandra Cannon, Chief, Office of Forensic Services at (614) 466-1099. You can also obtain a copy on-line at www.mh.state.oh.us. Click on "ODMH Publication" and scroll down to "Ohio Forensic Manual" (The manual contains 230 pages). Attached is a list of the current Forensic Monitors.

If you have questions, please call Vicki Jenkins at (614) 644-7342.

c: Distribution Lists

Enclosure

Appendix Y

Notice: Utilization of this document is at the sole risk of the agency or provider. As with any legal instrument or matter of legal interpretation, independent legal counsel should be consulted regarding use of forms and HIPAA compliance.

EXAMPLE

COMMUNITY FORENSIC MONITORING PROGRAM CONDITIONAL RELEASE COMMITMENT CLIENT STATEMENT OF UNDERSTANDING AND CONSENT

I understand that Conditional Release is a Court-ordered commitment, that I have a Conditional Release Plan, and a treatment plan that has been approved by the Court. I agree to abide by the conditions in my Conditional Release Plan/treatment plan while I am on Conditional Release.

I understand that I am committed to the _____Community Mental Health (CMH)/Alcohol Drug Addiction and Mental Health Services (ADAMHS) Board. The Board has designated _____, as my Community Forensic Monitor, who will monitor me during my Conditional Release commitment.

I understand that the Court, the Board, the Community Forensic Monitor, and my case manager are required to share information about me while I am on Conditional Release. Other individuals or agencies may be involved in my Conditional Release or treatment if designated by the Court for the purpose of monitoring my adjustment and progress in treatment.

I understand that I may be asked to sign an Authorization for Release of Information so that my family can receive information about my medication, treatment, and prognosis. I can designate who is involved and what information is provided.

I understand that my Community Forensic Monitor is required to provide regular reports about my status to the Court, the Board and the Ohio Department of Mental Health.

I understand that if I do not adhere to all of the conditions in my Conditional Release Plan/treatment plan the Court will be notified. The Court may choose to revoke my Conditional Release at any time if I am not compliant with all of the conditions specified in the plan.

I understand that if I decompensate and/or if I need to be re-hospitalized due to symptoms of my mental illness, the Court will be notified. If I am re-hospitalized for an extensive period of time the Court may choose to revoke my conditional release until I can return to the community.

I understand that the Court will hold regular hearings during my Conditional Release commitment and that I may attend these hearings. At any time, if I violate my Conditional Release Plan the Court may hold a hearing to determine if I will continue on Conditional Release or not.

Signature of Client /Date

Witness/Date

cc Client
CMH/ADAMHS Board
Forensic Monitor
Defense Attorney
Prosecutor

Appendix Z

Notice: Utilization of this document is at the sole risk of the user. As with any legal instrument or matter of legal interpretation, independent legal counsel should be consulted regarding any matters of HIPAA compliance.

EXAMPLE

COMMUNITY FORENSIC MONITORING PROGRAM AGENCY AGREEMENT TO TREAT

In accordance with Section 5119.57 and Chapter 340 of the Ohio Revised Code:

The (community mental health agency) agrees to provide mental health treatment services to (client) who has been granted Conditional Release from the (County) Court.

The agency is aware that Conditional Release is a commitment and that the client remains under the jurisdiction of the (County) Court and will be monitored by _____, Forensic Monitor for (County of the Committing Court) County.

The agency shall submit monthly progress reports, treatment plan/updates, community risk assessment (initial and updates), to the Court via the Forensic Monitor. The Alcohol Drug Addiction and Mental Health Board (ADAMHS) or the Community Mental Health Board (CMH) for the county of the committing court will receive monthly reports from the agency or _____, Forensic Monitor. If there are any changes in the client's compliance with the Conditional Release Plan, the Community Forensic Monitor is to be notified immediately.

The Forensic Monitor for (County of the Committing Court) County shall ensure that the (community mental health agency) receives a release of information form, and a statement of understanding and consent form all signed by the client. The client has a right to participate in the treatment planning, and a right to make decisions and choices about the treatment provided, within the restrictions imposed by the Court.

Agency Representative

Forensic Monitor

Title

County

Agency

Date

Appendix AA

Notification of Records Check

This procedure is to be followed by the RPH CCO/designee for cases in which the probate judge has not notified the bureau of criminal identification and investigation. For people who have been granted Conditional Release and who have not been discharged from an ODMH RPH, the Forensic Monitor is responsible to follow this procedure and complete the form that is referenced in the web link below.

Revised Code: 5122.311 Notification of bureau of criminal identification and investigation of adjudication of mental illness.

(A) Notwithstanding any provision of the Revised Code to the contrary, if, on or after the effective date of this section, an individual is found by a court to be a mentally ill person subject to hospitalization by court order or becomes an involuntary patient other than one who is a patient only for purposes of observation, the probate judge who made the adjudication or the chief clinical officer of the hospital, agency, or facility in which the person is an involuntary patient shall notify the bureau of criminal identification and investigation, on the form described in division (C) of this section, of the identity of the individual. The notification shall be transmitted by the judge or the chief clinical officer not later than seven days after the adjudication or commitment.

(B) The bureau of criminal identification and investigation shall compile and maintain the notices it receives under division (A) of this section and shall use them for the purpose of conducting incompetency records checks pursuant to section [311.41](#) of the Revised Code. The notices and the information they contain are confidential, except as provided in this division, and are not public records.

(C) The attorney general, by rule adopted under Chapter 119. of the Revised Code, shall prescribe and make available to all probate judges and all chief clinical officers a form to be used by them for the purpose of making the notifications required by division (A) of this section.

Effective Date: 04-08-2004

A copy of this form is available at:

<http://www.ohioattorneygeneral.gov/files/Forms/Forms-for-Law-Enforcement/Investigation-and-Identification/Miscellaneous-Forms/Notification-Form-for-Record-Checks>

Appendix BB

Revised Code Section [2305.51](#) describes the responsibilities of all mental health professionals and mental health organizations regarding their “duty to protect.” This applies to all patients/clients regardless of their forensic status.

2305.51 Mental health professional or organization not liable for violent behavior by client or patient.

(A)(1) As used in this section:

(a) “Civil rights” has the same meaning as in section [5122.301](#) of the Revised Code.

(b) “Mental health client or patient” means an individual who is receiving mental health services from a mental health professional or organization.

(c) “Mental health organization” means an organization that engages one or more mental health professionals to provide mental health services to one or more mental health clients or patients.

(d) “Mental health professional” means an individual who is licensed, certified, or registered under the Revised Code, or otherwise authorized in this state, to provide mental health services for compensation, remuneration, or other personal gain.

(e) “Mental health service” means a service provided to an individual or group of individuals involving the application of medical, psychiatric, psychological, counseling, social work, or nursing principles or procedures to either of the following:

(i) The assessment, diagnosis, prevention, treatment, or amelioration of mental, emotional, psychiatric, psychological, or psychosocial disorders or diseases, as described in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association;

(ii) The assessment or improvement of mental, emotional, psychiatric, psychological, or psychosocial adjustment or functioning, regardless of whether there is a diagnosable, pre-existing disorder or disease.

(f) “Knowledgeable person” means an individual who has reason to believe that a mental health client or patient has the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm to or causing the death of a clearly identifiable potential victim or victims and who is either an immediate family member of the client or patient or an individual who otherwise personally knows the client or patient.

(2) For the purpose of this section, in the case of a threat to a readily identifiable structure, “clearly identifiable potential victim” includes any potential occupant of the structure.

(B) A mental health professional or mental health organization may be held liable in damages in a civil action, or may be made subject to disciplinary action by an entity with licensing or other regulatory authority over the professional or organization, for serious physical harm or death resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient, only if the client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the

client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:

(1) Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section [5122.10](#) of the Revised Code;

(2) Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122. of the Revised Code;

(3) Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;

(4) Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:

(a) The nature of the threat;

(b) The identity of the mental health client or patient making the threat;

(c) The identity of each potential victim of the threat.

(C) All of the following apply when a mental health professional or organization takes one or more of the actions set forth in divisions (B)(1) to (4) of this section:

(1) The mental health professional or organization shall consider each of the alternatives set forth and shall document the reasons for choosing or rejecting each alternative.

(2) The mental health professional or organization may give special consideration to those alternatives which, consistent with public safety, would least abridge the rights of the mental health client or patient established under the Revised Code, including the rights specified in sections [5122.27](#) to [5122.31](#) of the Revised Code.

(3) The mental health professional or organization is not required to take an action that, in the exercise of reasonable professional judgment, would physically endanger the professional or organization, increase the danger to a potential victim, or increase the danger to the mental health client or patient.

(4) The mental health professional or organization is not liable in damages in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority over the professional or organization, for disclosing any confidential information about a mental health client or patient that is disclosed for the purpose of taking any of the actions.

(D) The immunities from civil liability and disciplinary action conferred by this section are in addition to and not in limitation of any immunity conferred on a mental health professional or organization by any other section of the Revised Code or by judicial precedent.

(E) This section does not affect the civil rights of a mental health client or patient under Ohio or federal law.

Effective Date: 09-15-1999

For patients in ODMH Regional Psychiatric Hospitals, the following rule ([OAC 5122-3-12](#)) applies. This rule contains forms that have been developed for use within ODMH Regional Psychiatric Hospitals. ODMH employees should use the link to the [OAC](#) to ensure that the most recent forms are accessed. Others may find the form included below to be useful and may modify it for their own use after consulting with their legal counsel.

5122-3-12 Duty to protect.

(A) The purpose of this policy is to implement the duty to protect requirements per section [2305.51](#) of the Revised Code.

(B) This policy shall apply to all mental health professionals employed or contracted by Ohio department of mental health hospitals.

(C) Definitions:

(1) "Independently-licensed mental health professional" means psychiatrists, psychologists, social workers, counselors and clinical nurse specialists licensed to independently provide mental health services.

(2) "Knowledgeable person" means any person who has reason to believe that a patient has the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm to a clearly identifiable potential victim(s), who is either an immediate family member of the patient, an employee of the hospital, or an individual who, otherwise, personally knows the patient.

(3) "Mental health professional" means any individual who is licensed, certified or registered under the Revised Code, or otherwise authorized in this state, to provide mental health services.

(D) Procedures:

(1) Any mental health professional to whom an explicit threat of serious physical harm to another person or persons or identifiable structure is made, or who is made aware by a knowledgeable person of an explicit threat made by a patient, will initiate the duty to protect process.

(2) Any explicit threat by a patient shall be promptly communicated by the mental health professional who heard the threat or was made aware of the threat, to a registered nurse or psychiatrist on the patient's treatment team. The treatment team shall determine, based on the patient's history and current condition, whether the threat represents a credible danger to others.

(a) If the treatment team does not consider the threat to be a credible danger to others, this decision and the reason for this determination shall be documented in the medical record.

(b) If the treatment team considers the threat to be a credible danger, the threat shall be reported promptly by the treatment team to the chief clinical officer or designee of the hospital.

(3) The chief clinical officer or designee of the hospital shall assign an independently-licensed mental health professional to conduct a face-to-face evaluation with the patient as soon as possible after receiving notification of the threat, but no longer than two working days, in order to give a second opinion risk assessment of the threat.

(4) If the independently-licensed mental health professional determines that the threat does not meet the threshold requiring discharge of the duty to protect (e.g., threat is not imminent), this assessment should be documented on a form authorized by the regional psychiatric hospital (RPH) or in a progress note in the medical record.

(a) Each RPH shall establish policies and procedures that assure patient re-evaluation occurs prior to the patient being discharged or receiving unsupervised movement, including placing a "Duty to Protect" sticker on the patient's chart and adding a "Duty to Protect" problem on the treatment plan. (See Appendix 1 [DMH-0040a] for "Duty to Protect Tracking Form" which may be used by the RPH to monitor procedure compliance).

(b) The independently-licensed mental health professional shall record, in a progress note or indicate on a RPH form, that the patient does not have either the intent or ability to carry out the threat and record the reason(s) for this conclusion.

(c) Other clinical recommendations may be considered for this patient and should be documented as appropriate in the medical record.

(5) If the independently-licensed mental health professional determines that there is an explicit threat of imminent and serious physical harm and there is reason to believe the patient has the intent and ability to carry out the threat, the independently-licensed mental health professional completing the RPH form or documenting this assessment in a progress note in the medical record, must address each of the relevant options to discharge the duty to protect in section [2305.51](#) of the Revised Code and indicate the reason(s) each was, or was not, chosen.

(a) Since the patient in these instances is already hospitalized, the relevant options for further action under section [2305.51](#) of the Revised Code for discharging the duty to protect are as follows:

(i) Establishing and undertaking a treatment plan that is reasonably calculated to eliminate the possibility that the patient will carry out the threat (having performed this second opinion risk assessment consultation); and

(ii) Communicating to a law enforcement agency either where the victim or patient resides and, if feasible, communicating with the potential victim(s) and/or guardian(s) about the threat;

(b) If the option chosen by the independently-licensed mental health professional is to warn the potential victim(s) and appropriate law enforcement agency, the independently-licensed mental health professional shall notify the chief clinical officer (or designee) who will designate the person to give the warning;

(i) The information about who was warned, what information was shared, and the time of the warning shall be documented on the RPH form (Appendix 2 [DMH-0040]) or in the progress note in the medical record; and

(ii) Information shared should be restricted to the name and the description of the patient, the nature of the threat, and the name of potential victim(s) and/or potential structure threatened.

(6) Progress notes in the medical record should reflect any contacts with consultants, chief clinical officer (or designee), or the patient's treatment team as appropriate.

(7) The RPH authorized form, or a copy of the progress notes about the threat should be filed in the legal section of the medical record. A copy should be forwarded to the legal assurance administrator of the hospital.

(8) If the threat is considered to be serious but not imminent, and the independently-licensed mental health professional believes the threat should be re-evaluated closer to unsupervised movement, conditional release or

discharge of the patient, the independently-licensed mental health professional will contact the treatment team social worker who will affix or cause to be affixed, a prominent sticker on the front of the patient's medical record noting a "Duty to Protect" and add a "Duty to Protect" problem to the treatment plan.

(9) When a "Duty to Protect" sticker is affixed to the medical record and a problem is added to the treatment plan, prior to unsupervised movement, conditional release or discharge, the treatment team social worker will notify the chief clinical officer (or designee) who will assign an independently-licensed mental health professional to conduct a face-to-face re-evaluation of the presence or absence of the threat, and if present, the credibility of the threat.

(10) If a patient with a "Duty to Protect" problem goes AWOL from a RPH, the treatment team (or on evenings, weekends, and holidays, the nurse manager) shall promptly give a recommendation to the chief clinical officer regarding warning law enforcement and, if feasible, potential victims in the community.

(11) In all re-evaluations, the independently-licensed mental health professional should locate the original RPH form or progress notes about the threat in the medical record or in the file of the legal assurance administrator.

(a) After the face-to-face re-evaluation, a new RPH authorized form or medical record progress note shall be completed and filed in the legal section of the medical record with a copy to the legal assurance administrator.

(i) If no active serious threat is present, this should be noted on the RPH form or in a progress note and no further formal action is necessary;

(ii) If an active, serious, and imminent threat remains, this should be documented on the RPH form or in a progress note and the actions identified in paragraphs (D)(5) to (D)(7) of this rule should be followed. In addition, the independently-licensed mental health professional shall promptly notify the treatment team for appropriate action regarding the pending unsupervised movement, conditional release, or discharge.

[Click to view Appendix](#)

[Click to view Appendix](#)

Effective: 08/05/2011

Promulgated Under: [111.15](#)

Statutory Authority: [111.15](#), [5119.01](#)

Rule Amplifies: [2305.51](#)

5122-3-12 Duty to Protect

Name of Patient	Date of Birth	Patient Number
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On _____ an imminent threat to seriously physically harm another identifiable person or structure was
(Date)

communicated to me by:

(Name of Person) (Relationship to Patient)

The nature of the threat was to:

to the following person(s) or structure.

A. Based on my knowledge of the patient, it is my judgment that the patient

does not have the intent or ability to carry out the threat because:

Note: If the patient does not have the ability or intent to carry out the threat, no further action is legally mandated. However, clinical steps should be considered.

OR

B. Based on my knowledge of the patient, it is my judgment that the patient

does have the intent or ability to carry out the threat.

Since the patient is already hospitalized in accordance with Ohio Revised Code Section 2305.51, I have initiated the following option(s) and, after consideration, have chosen not to pursue other options at this time, based on the following reasons, in order to fulfill my duty to protect potential victims from threatened violence.

(If Section B is selected, both Sections below must be completed)

Name of Patient	Date of Birth	Patient Number
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1. Establish and undertake a documented treatment plan reasonably calculated to eliminate the threat, and concurrently initiate a risk assessment and management consultation with a consultant (licensed independent mental health professional appointed by the Chief Clinical Officer or designee).

<input type="checkbox"/>	Chosen	<input type="checkbox"/>	Not Chosen
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Reason:

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2. Warning to law enforcement and, if feasible, intended victim(s).

<input type="checkbox"/>	Chosen	<input type="checkbox"/>	Not Chosen
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Reason:

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STEPS TAKEN to implement the option(s) I have chosen are: (include any person to whom a warning is given, as well as the date, time and specifics; or specify changes in the treatment plan or the initiation of the required consultation and name of consultant.

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Mental Health Professional (Print name)

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Mental Health Professional (Print name) Date

23a. Date that CR was First Granted by Court

Mo. Day Yr. []-[]-[]

23b. Date of Additional CR Granted by Court During the Current Reporting Period (Enter date only if CR has been previously revoked.)

Mo. Day Yr. []-[]-[]

23c. List Dates of All Previous CR (optional)

24. If any of the following events occurred during the reporting period, check the appropriate boxes and provide the dates of each occurrence. Check box if Yes.

A. Revocation of CR

[] (If CR was revoked, complete Item 25 below.)

Date of Revocation

Mo. Day Yr. []-[]-[]

B. ODMH Hospital

[] Admission
[] Discharge

Date of Admission

Mo. Day Yr. []-[]-[]

Date of Discharge

Mo. Day Yr. []-[]-[]

C. Private Psychiatric Hospital

[] Admission
[] Discharge

Date of Admission

Mo. Day Yr. []-[]-[]

Date of Discharge

Mo. Day Yr. []-[]-[]

D. Detention in Jail

[]

Date of Detention

Mo. Day Yr. []-[]-[]

Reason for Detention: _____

E. Arrest for Offense

[] Misdemeanor
[] Felony

Date of Arrest

Mo. Day Yr. []-[]-[]

F. Conviction for Offense

[] Misdemeanor
[] Felony

Date of Conviction

Mo. Day Yr. []-[]-[]

Name of Charge(s): _____

Name of Charge(s): _____

Court Disposition: _____

If sentenced to state prison (ODRC) and NGRI/IST-U-CJ commitment is not terminated, has detainer been issued by Prosecutor?

[] 1 = Yes
[] 2 = No

G. Violent Behavior/Prominent Risk Issues (threats, substance abuse, curfew violations, etc.)

[] (whether or not the behavior resulted in an arrest)

Describe: _____

25. Reasons for Revocation of CR (check all that apply)

[] Mental Illness/Decompensation
[] Substance Abuse
[] Arrest/Conviction (misdemeanor)
[] Arrest/Conviction (felony)

[] Other, Specify: _____
[] Violation of CR Plan, Specify: _____
[] Medication Noncompliance
[] AWOL

26. Compliant with Treatment

[] 1 = Yes
[] 2 = No

27. Date CR Commitment Terminated By Court (if applicable)

Mo. Day Yr. []-[]-[]

28. Reason CR Terminated

[] 1 = No Longer a Mentally Ill Person Subject to Hospitalization by Court Order [2945.401(J)(1)(a)]
[] 2 = Maximum Expiration of Commitment [2945.401(J)(1)(b)]
[] 3 = Restored to Competency and No Longer a Mentally Ill Person Subject to Hospitalization by Court Order [2945.401(J)(2)(a)(ii); Applies Only to IST-U-CJ]
[] 4 = Death, Cause of Death: _____
[] 5 = Other, Specify: _____

29. Expiration Date of Commitment (maximum time allowed by ORC)

Mo. Day Yr. []-[]-[]

30. Name (last, first) of Forensic Monitor for Legal/Committing County (Item 9)

31. Name (last, first) of Forensic Monitor for County of Current Address (Item 10)

IF Person is not Living in Legal/Committing County.
