

**A Report of Ohio's Acute Mental Health Care:
An Update Report of the 2004 "Crisis in Ohio's
Acute Mental Health Care."**

October - 2010

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The Ohio Department of Mental Health gratefully acknowledges the outstanding work of a number of individuals and organizations during the past two years in providing this comprehensive update to the 2004 Report on Ohio's acute inpatient psychiatric capacity. That report, titled "The Crisis in Ohio's Acute Mental Health Care," offered a number of insights regarding the status of Ohio's critical inpatient mental health care services.

In consideration of a number of major factors, ODMH recognized the need to provide a reassessment and current status of Ohio's inpatient public and private mental health system. In early 2008, with the support of the Transformation State Incentive Grant (TSIG), the Department authorized and pursued the update and scope expansion to the 2004 Report. The result of this work, "Ohio's Acute Mental Health Care: An Update Report of the 2004 Crisis in Ohio's Acute Mental Health Care" represents the combined effort and expertise of many mental health professionals.

I am pleased to acknowledge the significant work and contributions to the 2010 Report by Jeff Hill, L.I.S.W., for researching and writing the content material, and Karl Donenwirth for providing the rich data contained within its pages. Many ODMH staff also contributed greatly by researching, consulting, providing technical expertise and editing. These staff members include: Angie Bergefurd and Lynn Lyon (Medicaid Office), Rick Tully and Leslie Brower (TSIG Office), Bob Baker, Ph.D., Theresa Seagraves and Carrol Hernandez, Ph.D. (Program and Policy Office), Denise Cole (Office of Licensure and Certification), Terry Watts, Jeff Ryan, Michael Schroeder and Dushka Crane-Ross, Ph.D. (Medical Director's Office), Vince Conner (Human Resources), Dalon Myricks and Holly Jones (Fiscal Office), Trudy Sharp (Communications Office), Carol Carstens, Ph.D. (Office of Research and Evaluation) and Andrea Garringer (Hospital Services). Their hard work and tireless efforts on this project are to be commended.

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We believe that the combined knowledge and dedication of those who worked on this report helped to make it a significant contribution to the field. In addition to updating the 2004 Report, this document provides further insights, thoughts and themes for consideration for inpatient mental health care. We hope these issues will remain in the forefront during the delivery of inpatient mental health care in Ohio.

Jim Ignelzi, Deputy Director
Ohio Department of Mental Health

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Part I

Introduction

Part I

Introduction

This document is an updated report of the status of “The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem” (herein referred to as the 2004 Report) initially published in April 2004. It is funded in part through the Transformation State Incentive Grant (TSIG) awarded to the Office of the Governor by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance system transformation planning. The Ohio Department of Mental Health (ODMH) provided overall leadership and management of the five-year TSIG grant.

In the introduction of the 2004 Report it was noted that “the changes have occurred over a number of years, but at a slow and insidious rate. Taken together, the changes have been a series of quiet storms rather than occurring all at once like a major hurricane. The cumulative effect, however, is a crisis of significant proportions.”¹ To continue the 2004 Report’s meteorological analogy, the storms have certainly intensified if not yet to the magnitude of a hurricane, certainly that of a severe tropical storm. The 2004 Report brought to sharp focus the problem dimensions. However, little substantive improvements took place in the intervening three years. Despite the current economic crisis gripping our country and state, the time for decisive and concerted action is at hand.

The President’s New Freedom Commission on Mental Health noted in 2003 that “mental illnesses rank first among illnesses causing disability in the United States, Canada, and Western Europe.”² The Surgeon’s General’s Report on Mental Health estimated that “about 10 percent of the U.S. adult population use mental health services in the health sector in any given year.”³ The Surgeon General’s Report also noted that for adults, “untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.”⁴

The President’s New Freedom Commission on Mental Health also noted that in addition to the “tragedy of lost lives, mental illnesses come with a devastatingly high financial cost.”⁵ The Commission reported that in the United States, “the annual economic, indirect cost of mental illnesses is estimated to be \$79 billion. Most of that amount – approximately \$63 billion – reflects the loss of productivity as a result of mental illnesses. But indirect costs also include almost \$12 billion in mortality costs (lost

¹ *The Crisis in Ohio’s Acute Mental Health Care Report*: April, 2004, p. 4.

² *President’s New Freedom Commission on Mental Health, Executive Summary*, July, 2003, p. 3.

³ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, p. 15.

⁴ *Ibid.*, p. 18.

⁵ *President’s New Freedom Commission on Mental Health, Executive Summary*.

productivity resulting from premature death) and almost \$4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care.”⁶

The Surgeon General’s Report detailed that “in 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer’s disease cost the Nation \$99 billion; direct cost for mental disorders alone totaled \$69 billion.”⁷ The Substance Abuse and Mental Health Services Administration (SAMHSA) calculated that the national cost for mental health services alone reached \$100 billion in 2003. SAMHSA estimates that the cost for mental health services will double by 2014 to \$203 billion!⁸ On a per capita basis, nationally the cost of mental health services tripled from 1986 to 2003 (\$136 per person to \$339 per person, respectively) and it is forecasted to increase to \$626 per person in 2014.⁹ Nationally, mental health only spending is projected to grow by 6.6 percent annually from 2003 to 2014.¹⁰

Based on the above national cost calculations, we can extrapolate the cost of mental health services for Ohio. The estimated cost of mental health services in the Buckeye State was more than \$ 3.8 billion in 2003. By 2014 the cost is projected to be over \$ 7.2 billion. These cost estimates are based on the approximate state population projections for these time periods.¹¹

While the cost for mental health spending is projected to continue to rise, the percentage of total health care spending is growing by an even greater percentage. SAMHSA calculates that for the period 2003 to 2014, all health care costs will increase by 7.2 percent compared to the 6.6 percent increase estimated for only mental health costs.¹²

Taken as a percentage of total health care costs, mental health spending comprised 6.2 percent in 2003. The percentage of total health care cost consumed by mental health is projected to decline to only 5.9 percent by 2014.¹³ The primary reason is that the principal driver of total health care cost increases continues to be high cost technology. High cost technology is less of a factor in the mental health field than in other health care fields.¹⁴ For the mental health field, historically and until recently, the principal driver has been total hospital costs.¹⁵

⁶ Ibid.

⁷ Surgeon General’s Report on Mental Health, p. 20.

⁸ Katherine R. Levit, et al. Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004 – 2014. SAMHSA Publication No. SMA 08-4326. Rockville, Maryland: Substance Abuse and Mental Health Services Administration, 2008, p. 17.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Estimated population is based on National Research Institute, Table 23 for FY 2003 through 2005. Ohio’s population is projected to grow by a modest 0.10 percent during the forecast period.

¹² Levit, p. 18.

¹³ Ibid.

¹⁴ Ibid., p. 16.

¹⁵ Ibid., p. 22.

However, increasingly, the principal driver of mental health costs is prescription drug expenditures. Prescription drug costs accounted for seven percent of the total mental health expenditures in 1986. By 2003, prescription drugs comprised 23 percent of total mental health expenditures. By 2014, the estimate is that prescription drugs will account for 30 percent of the total mental health expenditures, surpassing total hospital costs as the largest percentage of mental health expenditures.¹⁶

The distribution of public to private payer expenditures on mental health services is predicted to increase by the same 6.6 percent from 2003 to 2014. While the increase is the same, the percentage of total distribution is not. Public monies account for 58 percent of all mental health expenditures while private expenditures account for 42 percent.¹⁷ The principal reason for the disparity was the onset of managed care strategies in the private sector that contributed to lower private inpatient utilization. The cost savings derived leveled off and now both sectors are hit with the rising cost of prescription medications.¹⁸

The pervasiveness and high cost of mental illness does not affect only the mental health system; the general health system also feels the strain. Many states are experiencing increased demand in emergency departments for psychiatric crisis care. Additionally, the President's New Freedom Commission on Mental Health cited a number of studies that show persons with common medical disorders often have high rates of depression and anxiety. These physical health conditions include cardiovascular diseases, diabetes and hypertension.¹⁹

The purpose of this updated report is to call renewed attention to acute care issues that are continuing to plague many states, including Ohio, and the adverse effect of these issues on the total health care system.

What is Acute Care?

President George W. Bush convened the New Freedom Commission on Mental Health that was chaired by the former Director of the Ohio Department of Mental Health, Dr. Michael Hogan. The Commission's subcommittee on Acute Care defined acute care as:

- Short-term (with a median length of stay of approximately 30 days or fewer), 24-hour, inpatient care and emergency services provided in hospitals;
- Short-term, 24-hour care provided in residential treatment facilities for children; and
- Treatment in other crisis and urgent care service settings.

¹⁶ *Ibid.*

¹⁷ *Ibid.*, p. 19.

¹⁸ *Ibid.*

¹⁹ President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003, p. 21.

The Subcommittee on Acute Care also indicated that “Appropriately managing acute care needs requires a comprehensive community mental health system with a full range of effectively coordinated components and a wide range of other services in a community appropriate for people with mental illnesses across the life span....In some communities, the shortage of acute care beds has risen to crisis proportions. Too often budget shortfalls have reduced funding for other essential community mental health services, consequently increasing the demand for already limited inpatient care as an alternative.”²⁰

Ohio’s experience with the problem of acute care beds mirrors the situation found throughout the nation. The anticipated impact identified in 2004 is becoming all the more apparent in 2010. That is, “the decreased availability of acute care services impacts other community resources and services. If acute care beds are difficult to access, the effect may be experienced not only in the mental health community, but also in other systems such as the criminal justice system or the general health care system.”²¹ For the past 15 years at least, Ohio’s inpatient mental health system has been under enormous pressure from multiple influences. These changes have been documented in Ohio and across the country for all age groups in both the public and private systems. The continuing trend indicates that there will be little to no relief for patients needing emergency and inpatient mental health services. What is needed is concerted action to buck the trend and provide a meaningful correction. This updated report will not only provide the present status of the crisis in inpatient services, but go beyond to posit a detailed list of recommendations that it is believed will positively impact on the status of inpatient acute care psychiatric services in Ohio.

Taking advantage of the opportunity offered by the TSIG funding, an attempt was made to better identify the present status of inpatient services in Ohio. ODMH worked with stakeholders to solicit the experiences, opinions and suggestions of the local ADAMH/CMH Boards and service providers. ODMH contracted with the Ohio Association of County Behavioral Health Authorities to conduct a survey of Boards. A copy of the survey instrument and the results can be found in Appendix B. ODMH also contracted with the Ohio Council of Behavioral Healthcare Providers to solicit survey responses from those agencies who are directly involved in the pre-screening process for inpatient psychiatric hospitalization. That survey instrument and the results is in Appendix C. ODMH also worked with the Ohio Hospital Association in surveying their members’ perspective on current access to care issues. Pertinent findings from these surveys are highlighted in the Community Perspectives part of the document.

ODMH staff actively participates on the Hospital Services Work Group Committee through monthly meetings at the offices of the Ohio Association of County Behavioral Health Authorities. Additional participants are Board staff and members, key staff from the Ohio Council of Behavioral Healthcare Providers and the Ohio Hospital Association. Through this committee, issues pertaining to inpatient care are discussed and recommendations generated.

²⁰ Ibid.

²¹ *The Crisis in Ohio’s Acute Mental Health Care Report*: 2004, p. 4.

Part II

Access and Capacity of Ohio's Inpatient System

PART II

Access and Capacity of Ohio's Inpatient System

The 2004 "Crisis in Ohio's Acute Mental Health Care" report highlighted the decrease in inpatient bed capacity in the state. The report noted that "many publications, journal articles, reports, and private correspondences have documented the decrease in both public and private inpatient psychiatric beds nationwide. The National Association of Psychiatric Health Systems (NAPHS) estimates that state mental hospital beds decreased 32 percent from 1992 to 2000 and private psychiatric hospital beds declined 23 percent."²²

Since that report, the national downward trend continues. In September 2005, the National Association of State Mental Health Program Directors' (NASMHPD) Research Institute reported, "over the past five years, (23 of 39) states have experienced declines in the number of general hospital psychiatry beds and 22 states have experienced a decline in the number of private psychiatric hospital beds."²³ The report also noted that "nearly half of the states (20 of 45 responding) are reorganizing their state hospitals, including downsizing, reconfiguring, closing and/or consolidation."²⁴

NASMHPD further noted that from 1970 to 2002 there has been a nationwide decrease of over 85 percent in the number of residents in state run hospitals (from 337,691 to 49,443 residents) and during the same period the number of hospitals also declined by 30 percent (from 315 to 220 hospitals).²⁵ In 2004, many of the states were actively engaged in decreasing beds, closing hospitals, or replacing older facilities with new ones. Only two states considered increasing the number of beds in their facilities: Maine and Texas. Ohio's experience is consistent with the collection of states involved in reorganizing, downsizing and consolidation of its state hospitals. The national result is a reduction in state operated psychiatric beds from 339 per 100,000 population in 1955 (the zenith year for the number of inpatients nationally) to 22 beds per 100,000 population.²⁶

The issue of the decline in state psychiatric beds is further exacerbated as "a greater number of state psychiatric hospital beds are specifically earmarked for forensic, sexual

²² Kate Mulligan, "DB Seeks Solution to State's Shortage of Psychiatry Beds" in *Psychiatric News*, Vol. 37, No. 18, September 20, 2002.

²³ National Association of State Mental Health Program Directors Research Institute, "State Psychiatric Hospitals: 2004," *State Profile Highlights*, No. 05-3, September 2, 2005.

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ H. Richard Lamb and Linda E. Weinberger, "The Shift of psychiatric hospital inpatient care from hospitals to jails and prisons," *Journal of the American Academy of Psychiatry and the Law Online*, 33:4: p. 529, 2005.

predator and other specific populations.”²⁷ At the September 2006 focus group meeting of the National Association of State Mental Health Program Directors on the topic of the crisis in acute psychiatric care, it was noted that “a total of 1,416 state psychiatric hospital beds were allocated nationally for forensic purposes in 2004.”²⁸ The present number of beds for forensic purposes was an increase from the number reported in 2002 to the NASMHPD Research Institute State Profiling System. Most notable were increases in forensic beds in Florida (up 42 per cent), Illinois (up 34 percent) and Texas (up 36 percent) in the past two years.²⁹

Ohio experienced a similar increase in the number of beds occupied by forensic status patients. From FY 1998 to 2008, the number of bed days used by forensic status clients increased from 163,488 to 192,246 non-billable days, an increase of 18 percent.³⁰ “Billable” bed days are days charged to the patient’s ADAMH Board at a rate set every year. Billable days include voluntary, probate court commitments (including civil and incompetent to stand trial), and the maintenance of competency to stand trial. “Non-billable days” are not charged to the ADAMH Board, but are rather paid for ODMH. Non-billable days include forensic statuses of Not Guilty by Reason of Insanity, Competency Restoration, and Incompetent to Stand Trial, under Criminal Jurisdiction.

The focus group cited, “these allocations — resulting from policy, political, statutory and clinical considerations — reduce the number of state psychiatric beds that are available to persons with acute mental health needs who do not fall into one of the identified ‘set-aside’ categories.”³¹

NASMHPD concluded that “the impact of all these closings is that over 74 percent (35 of 47) of the states are experiencing a shortage in psychiatric beds.”³² Ohio is included in the 74 percent experiencing a shortage in psychiatric beds.³³ In fact all of the states that are contiguous to Ohio are in the same status except for Pennsylvania. The shortage of beds is further broken down into acute care, long-term and forensic beds. By far, the largest number of states were experiencing a shortage in acute care beds (34 states), compared to long-term care beds (14 states) and forensic-status beds (12 states).³⁴

²⁷ Bruce D. Emery, “The Crisis in Acute Psychiatric Care: Report of a Focus Group Meeting, June 198-20, 2006, Washington, D.C.”, National Association of State Mental Health Program Directors, p. 3.

²⁸ Ibid.

²⁹ Ibid., pp. 3-4.

³⁰ ODMH, Patient Care System Report, “Forensic Bed Day Trends: Shows Bed Days Based on Admitting Legal Status”, September, 2008.

³¹ Emery, p. 3-4.

³² National Association of State Mental Health Program Directors Research Institute, “State Psychiatric Hospitals: 2004,” *State Profile Highlights*, No. 05-3, September 2, 2005.

³³ Ibid.

³⁴ Ibid.

How Many Beds are Needed?

Subhead should be at top of this page

A loss of beds does not necessarily equate to a shortage of beds. **A determination of a shortage of beds requires consideration beyond just a loss of beds.** The shortage of beds needs to be in comparison to an accepted defined standard of need. Dr. E. Fuller Torrey, *et. al.*, with the Treatment Advocacy Center (TAC) posited a definition of just how many public psychiatric beds are needed. The TAC report is entitled *The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center*.³⁵ At the outset, Dr. Torrey's TAC study noted that "surprisingly, almost nothing has been written on this question, and there are no federal guidelines. It is a difficult question to answer because it depends on several factors."³⁶ The factors cited were:

- 1) Number of seriously mentally ill persons who are potential candidates for admission;
- 2) Number of seriously mentally ill persons who need hospital admission;
- 3) The average length of stay for a patient in a hospital;
- 4) The number of short stay versus long stay beds;
- 5) How the inpatient beds are financed.³⁷

The TAC determined that for 2004-2005, 11 states fell in the most critical bed shortage category (less than 12 beds per 100,000 population) including Ohio. Twenty-one states were in the severe bed shortage category (12 to 19 beds per 100,000 population), 16 states were in the serious bed shortage category (20-34 beds per 100,000 population), one (South Dakota) was in the marginal range (35-49 beds per 100,000 population), and only one state (Mississippi) just barely met the TAC minimal standard of 50 beds per 100,000 population.³⁸

The 2006 State Mental Health Profile Report compiled by the Treatment Advocacy Center ranked Ohio forty-third in the country in terms of the number of public psychiatric beds per 100,000 populations. See Figure No. 1 on the next page.

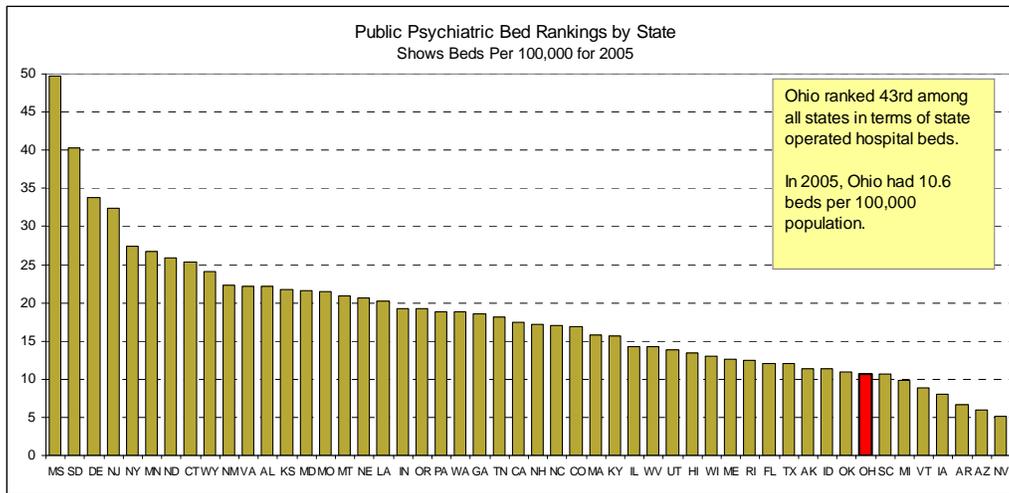
³⁵ E. Fuller Torrey, *et al.*, *The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center*, 2008, p. 1.

³⁶ *Ibid.*, p. 6.

³⁷ *Ibid.*, p. 8.

³⁸ *Ibid.*, p. 9-10.

Figure No. 1.



Sources: National State Mental Health Program Directors (NASMHPD) 2006 State MH Profile Report; March 2008 report by Treatment Advocacy Center

Several other studies have posited that many people with mental illnesses who need to be treated in an acute care psychiatric hospital are finding themselves incarcerated in county jails and state prisons. The TAC study cited that “consequence of the radical reduction in public psychiatric hospital beds has been a massive increase in severely mentally ill persons in jails and prisons.”³⁹ The National Commission on Correctional Healthcare estimated that between 16 and 24 per cent of persons incarcerated in jails and prisons are suffering from a major mental health disorder,⁴⁰ or 113 per 100,000 general population.⁴¹ According to the Ohio Department of Rehabilitation and Correction (ORC), in 2009 there were 4,471 inmates classified as severely mentally ill (C-1), which comprised nine percent of the total prison population. ORC does not track the number of persons who suffer from severe mental illness and are incarcerated in the county correctional facilities.⁴²

Another consequence often cited is the increase of homeless persons who live with a major mental illness. Fred E. Markowitz conducted a study of 81 cities in the United States and found “that public psychiatric hospital capacity has a statistically negative effect on crime and arrest rates, and that hospital capacity affects crime and arrest rates in part, through its impact on homelessness.”⁴³

³⁹ *Ibid.*, p. 12.

⁴⁰ National Commission on Correctional Health Care: The health status of soon-to-be-released inmates: a report to Congress. Washington, DC: National Commission on Correctional Health Care, 2002.

⁴¹ Lamb and Weinberger, p. 529.

⁴² Teresa Moorman-Jamison contact with bureau Chiefs at Ohio Department of Rehabilitation and Corrections, 2009 data.

⁴³ Fred E. Markowitz, “Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates,” *Criminology*, 2006:44:1, abstract.

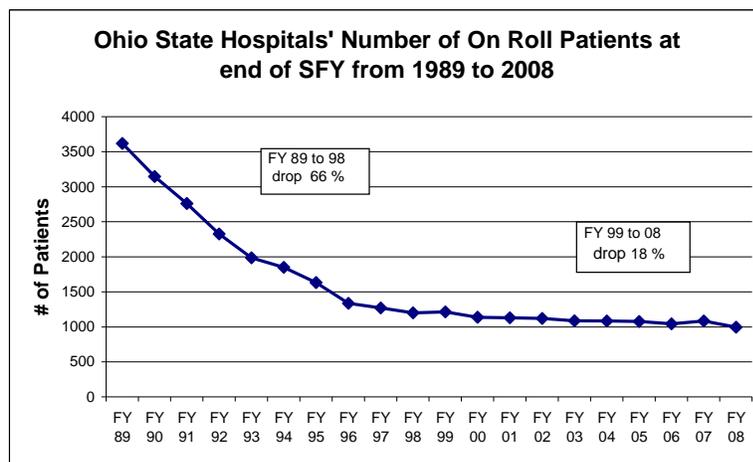
John R. Belcher's 1988 study for ODMH (though admittedly dated) found that 36 percent of persons discharged from state psychiatric hospitals in Ohio were homeless within six months of discharge.⁴⁴ Whether or not the resulting homelessness was due to people being released from the hospital who were not ready or rather a result of inadequate community support, the thrust of the study's findings were that Ohio needed to (at the time), develop a model that provided for a continuum of services. The study helped to support the rapid development of an array of best practices community-based services in the state during the last decade of the 20th century. The question remains open as to whether there is a causal relationship between homelessness and a reduction in state psychiatric beds. Clearly, the increasing prevalence of persons who are homeless speaks to the ongoing need for all human services to address the multi-faceted issues and needs that confront this vulnerable population everyday. Would an increase in the number of psychiatric beds reduce the prevalence of homelessness? That remains an open question.

State Psychiatric Hospital Beds in Ohio

State Hospital Utilization Change from 1989 to 2008

From 1989 to 2008, the number of patients on rolls at the Ohio state hospitals has declined by 72 percent. The census decline was most precipitous during the first 10 years of this period when the on rolls census declined by 66 percent. However, beginning in 1999, the decline in the census has moderated, only declining 18 percent over the most recent 10-year period. See Figure No. 2.

Figure No. 2.



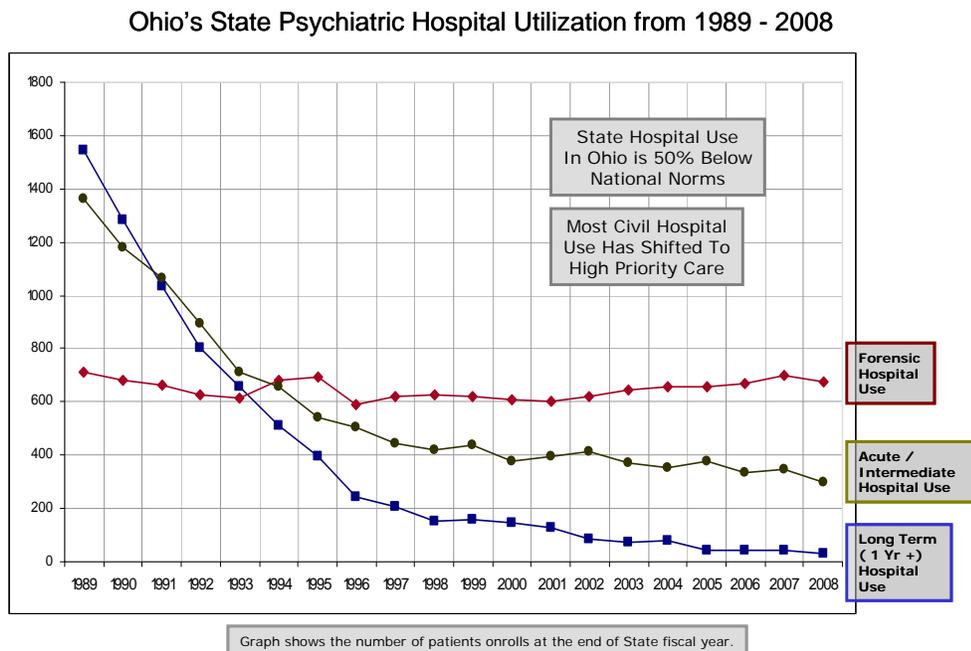
Source: ODMH, Patient Care System

Several marked differences are noted in the breakdown of the total numbers into three categories: Acute/Intermediate Care (defined as length of stay of less than a year),

⁴⁴ John R. Belcher, "Defining the Service Needs of Homeless Mentally Ill Persons," *Hospital and Community Psychiatry*, 1988:39:11:1203-1205.

Long Term Care (length of stay in excess of one year), and non-billable forensic care. The Acute/Intermediate Care Population continued to decline from 2004 to 2008, though at a more gradual rate of 15 percent total or three percent annually. The Long Term Care Population also continued to decline at a higher rate than the Acute/intermediate Care. Since 2004, the Long Term Care population has declined a total of 65 percent, or 13 percent annually. The Long Term Care Population has experienced the greatest decline since 1989, dropping from 1,543 patients in 1989 to just 28 remaining in 2008; a decline of 98 percent. Conversely, the number of non-billable forensic status patients has increased slightly from 2004 to 2008; a total increase of three percent or less than one percent annually. The number of non-billable forensic patients increased from 668 to 699 from 2006 to 2007, and then dropped back down to 672 in 2008. See Figure No. 3.

Figure No. 3.



Number of Discharges and Length of Stay

The 2004 Report included a profile that identified the three patient categories noted above, and compared the categories in terms of the number and percentage of discharges and the median length of stay for fiscal year 2003. The length of stay definitions for Acute and Long Term Care are different than the definition in the previous chart. See Figure No. 4 on the following page for the definition of these categories, and an updated comparison with the similar category data from fiscal year 2008.

Figure No. 4.

Profile of State Hospital Patients: FY 03 to FY 08
Patient Category

	Acute <= 45 days	Long Term > 46 days	Forensic Status
# Discharges			
FY 03	4678	748	862
FY 08	4588	762	852
Net Change	-90	14	-10
% Change	-1.9%	1.8%	-1.1%
% of Patients			
FY03	74%	12%	14%
FY 08	74%	12%	14%
Net Change	No Change	No Change	No Change
Median LOS			
FY 03	9	80	70
FY 08	12	80	92
Net Change	3	0	22
% Change	33%	0%	31%

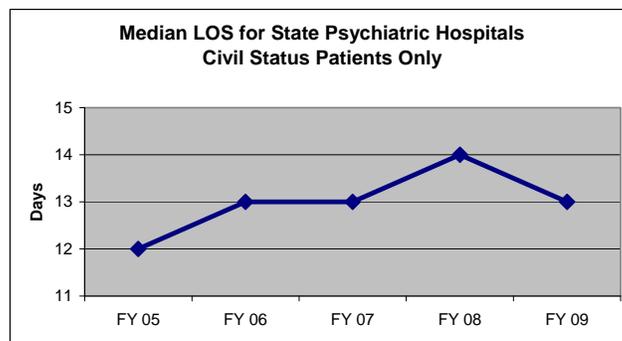
Source: Patient Care System

In terms of total number of discharges, Acute Care continues to be dominant. From FY 2003 to FY 2008, the changes were minimal within the three categories. On the other hand, the median length of stay has increased for the Acute Care and the non-billable Forensic populations. Increases in median length of stay exceeding 30 percent can have a direct bearing on the availability of beds.

Looking at the median length of stay from FY 2005 to FY 2009 for civil status patients only (acute and long term care), we find slight variation from year to year. Generally, the median length of stay has been between 12 and 14 days. See Figure No. 5.

Figure No. 5.

Median Length of Stay for State Hospitals for Civil Status Patients Only



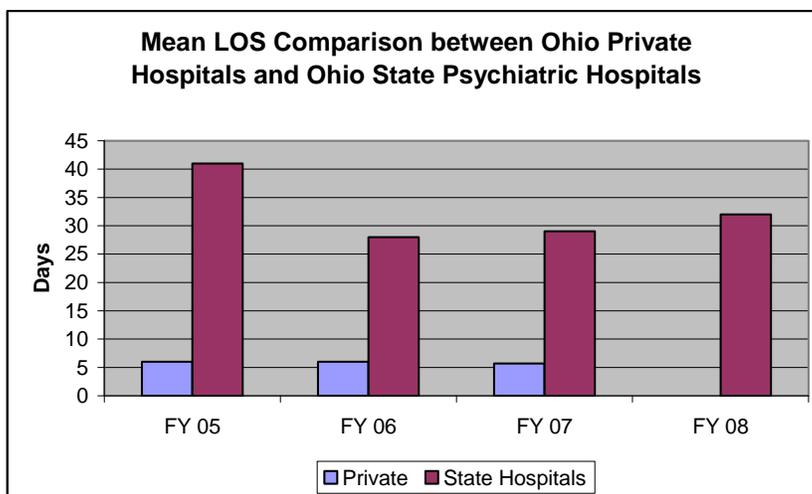
Source: Patient Care System

The mean length of stay data would suggest that for the civil status only patients the state psychiatric hospitals provide primarily acute care level of services with overall lengths of stays several times the average length of stay experienced in private psychiatric hospitals in Ohio from 2005 to 2007.⁴⁵ Some of the differences in the two

⁴⁵ Ohio Hospital Association, OHA Statewide Clinical and Financial Database, August, 2008.

data sets may be attributed to funding, that is the DRG- based Medicaid and managed care practices. See Figure No. 6. Other considerations of the length of stay differences might include case complexity and the degree of violence of patients served in the public and private settings. The mean as a measure of central tendency, is generally more susceptible to wide ranges in the data than is the median. This may also account for the higher mean LOS for the state hospitals where the discharge of patients who have been hospitalized for an extended period of time can skew the mean data. The median LOS for the civil patients in the state hospital was 12 days in FY 2005, 13 days in FY 2006 and 2007, and 14 days in FY 2008.⁴⁶ In addition, the practice of many psychiatric hospitals is seeking the transfer to the state hospital for patients who are considered to need a longer term of care.

Figure No. 6.



Source: Patient Care Systems for State Hospital Data; MI by Payer Spreadsheet, 8/25/2008 for private hospital data.

Hospital “Downsizing”, Reengineering and Efficiency

The decline in the non-forensic patient population of the state psychiatric hospitals has resulted in reengineering initiatives to create or achieve greater efficiencies. Although the changes can be in part attributed to the national decline in state hospital use from the continuing deinstitutionalization activities discussed in Appendix A of this report, in Ohio the implementation of the Mental Health Act of 1988 accelerated these efforts.

Amended Substitute Senate Bill 156, now known as the Mental Health Act of 1988, was signed into law on March 28, 1988. The Mental Health Act of 1988 (MHA) established Ohio’s “commitment to addressing the mental health needs of Ohioans through a unified system of community-based services. The law more fully defined the roles and responsibilities of the community mental health boards and the Ohio Department of

⁴⁶ ODMH, Patient Care System data.

Mental Health (ODMH).”⁴⁷ The MHA required that ODMH would continue to provide the full spectrum of mental health services, including “not only by operating state hospitals, but also by operating other community-based services and may deploy its staff in community settings and locations.”⁴⁸ A major tenet of MHA was the establishment of the mental health boards “as the single authority for the mental health system in each community, especially for children, adolescents and adults who are severely mentally disabled.” The board is responsible to provide a plan to ODMH that includes “a list of the services the board intends to purchase, a projection of inpatient and community-based services the board proposes that ODMH operate, an assessment of the number and types of residential facilities needed, proposed use of funds and budgets and other information requested by ODMH.”⁴⁹

In addition, the mental health boards are “to establish, to the extent resources are available, the essential elements of a community support system that would locate people in need and inform them about available mental health services; assist clients with meeting basic human needs; provide mental health services; provide emergency services and crisis intervention; assist clients with vocational services and opportunities; develop clients’ social, community and personal living skills; provide access to housing and residential treatment and support; assist families, friends and consumers; recognize and encourage natural support systems; provide grievance procedures and protect client rights and provide case management.”⁵⁰

While the ADAMH Boards gradually reduced the number of bed days they would purchase for inpatient state hospital care, the result necessitated the closure and consolidation of ODMH facilities. These closures and consolidations generally resulted in improved cost efficiencies that helped provide additional revenue to meet the current expenses. The desired result was an increase in the funds available to the ADAMH boards to plan for and fund community based care.

Unfortunately, beginning in 1997 and continuing for a decade, ODMH experienced gradual erosion in the general revenue funds. The result was increased pressure to further consolidate and find fiscal efficiencies. As could be anticipated, at some point, the continual decline in the number of beds would meet the critical mass. At this point, there no longer was a surplus and even a shortage of beds to meet the inpatient demand. The shortage of beds became particularly manifest when the civil bed demand leveled off and at the same time, the forensic bed demand experienced an increase. Below is an update to a familiar graph that chronicles the decline in the number of patients and hospital staff since 1991. See Figure No. 7 on the next page.

⁴⁷ Ohio Department of Mental Health Web Site: <http://mentalhealth.ohio.gov/who-we-are/system-history/the-mental-health-act.shtml>

⁴⁸ Ibid.

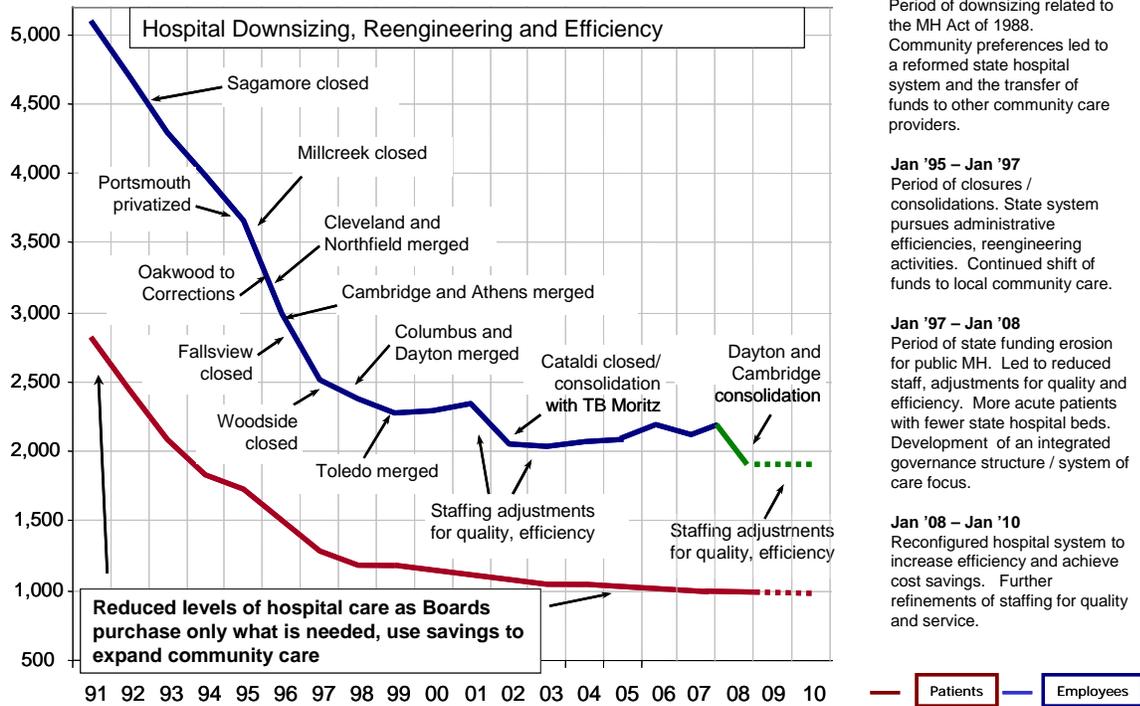
⁴⁹ Ibid.

⁵⁰ Ibid.

Figure No. 7.

Dec 30, 2008

Ohio Department of Mental Health FY 1991 through FY 2010



Billable Bed Days

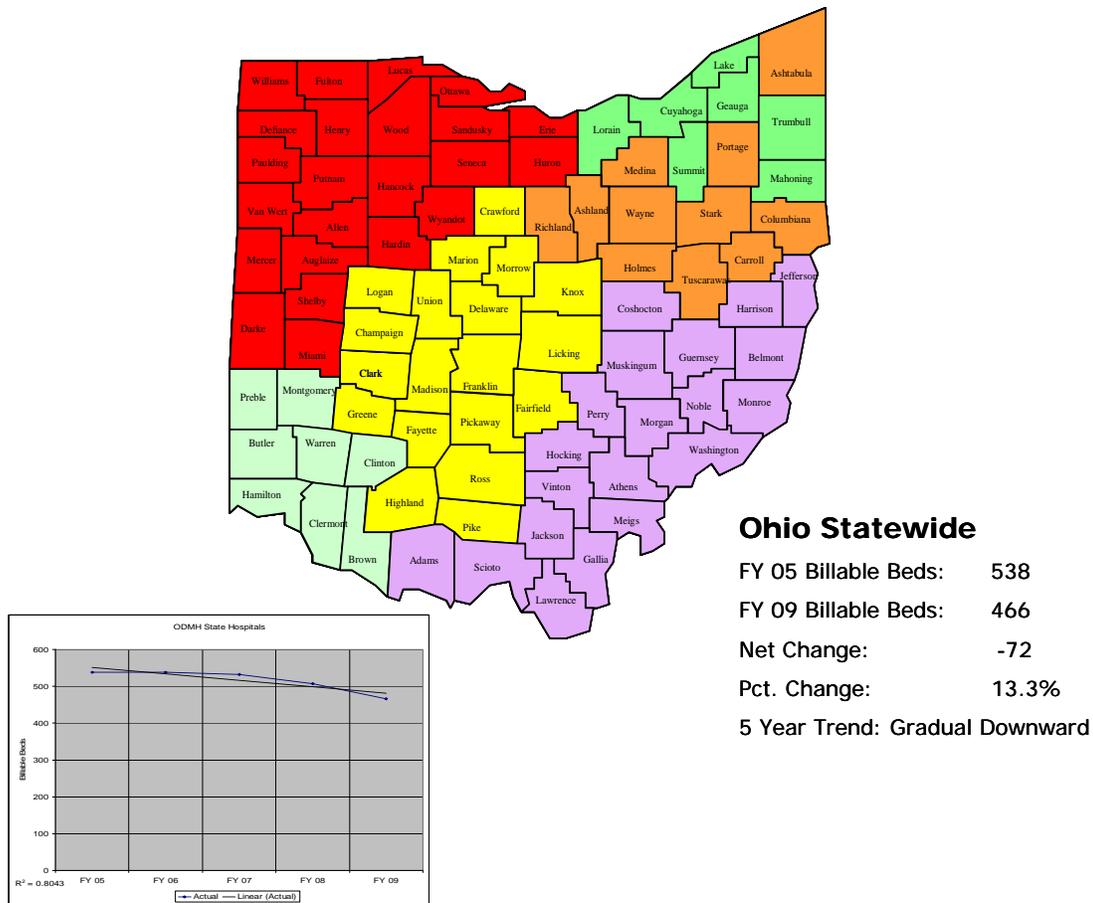
The ADAMH Boards are charged a per diem rate for each bed day that one of their patients occupies a state hospital bed. The Board is billed bed days for what are termed “billable days,” i.e. voluntary, emergency or probated admissions as well for certain forensic statuses. The forensic statuses for which the Boards are billed include: Incompetent to Stand Trial, Non-Restorable probated; Competency to Stand Trial and Not Guilty by Reason of Insanity evaluations; and maintaining a patient Competent to Stand Trial while awaiting the trial date.

The collective bed days (calculated into ‘Billable Beds’) compiled by all the Boards in each hospital region and the state are important to analyze in terms of change, trends and forecasting for potential bed needs in the near future. (To calculate the beds from bed days, simply divide the bed days by 365. To calculate bed days from beds, just reverse the calculation.) At the same time, the billable bed days comprise only one part of the equation; the non-billable forensic bed days are the other part of the equation and will be discussed in Part IV.

Bed Utilization

Comparing FY 2005 to FY 2009, the statewide change in the number of billable beds used by the ADAMH Boards has declined by 72 beds; a decline of 13 percent. The overall trend for the past five years has been a gradual downward trend. See Figure No. 8.

Figure No. 8.



By each state hospital region, we find the following results: (Note: the billable beds were calculated for each hospital region using the Board areas that are assigned to the hospital region as of the beginning of FY 2009. With the closure of the Dayton and Cambridge campuses, there were several reassignments of Board areas to state hospitals that are reflected in the present configuration.) The hospital regions include the following state facilities:

Southeast Region -- Appalachian Behavioral Healthcare in Athens

Northwest Region -- Northwest Ohio Psychiatric Hospital in Toledo

Southwest Region -- Summit Behavioral Healthcare in Cincinnati

Northeast Region -- Northcoast Behavioral Healthcare in Cleveland and Northfield

North Central Region -- Heartland Behavioral Healthcare in Massillon

Central Region -- Twin Valley Behavioral Healthcare in Columbus

Southeast Region

For the Southeast Region, there was a net decline of 12 billable beds used when comparing FY 2009 to FY 2005; a decline of 23 percent. The five-year trend has been a steady decrease in the number of billable beds used in the region.

Figure No. 9.

Southeast Region Utilization

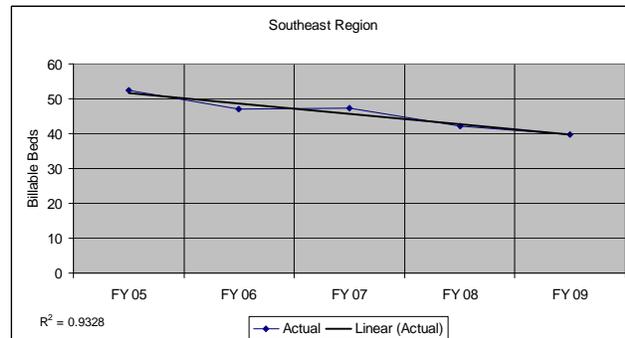
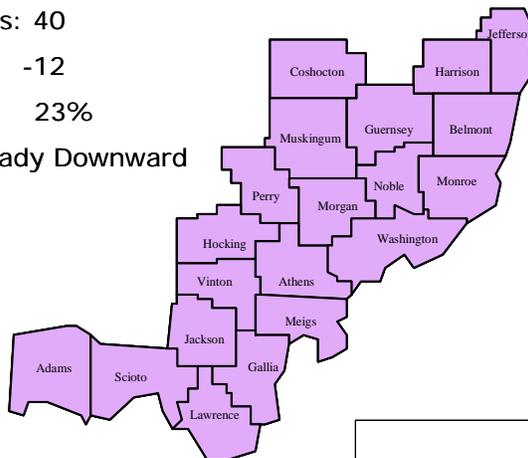
FY 05 Billable Beds: 52

FY 09 Billable Beds: 40

Net Change: -12

Pct. Change: 23%

5 Year Trend: Steady Downward



Southwest Region

The Southwest Region of the state experienced a decline of 38 beds used in FY 2009 from FY 2005; a drop of 25 percent.

Figure No. 10.



Southwest Region Utilization

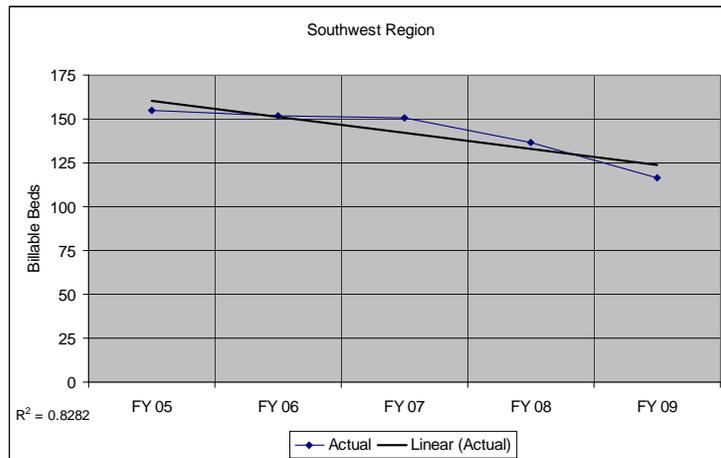
FY 05 Billable Beds: 155

FY 09 Billable Beds: 117

Net Change: -38

Pct. Change: 24.5%

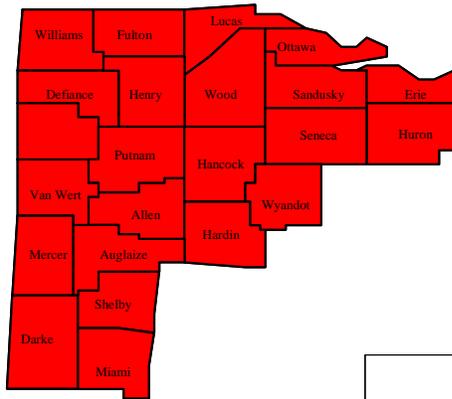
5 Year Trend: Steady Downward



Northwest Region

The Northwest region experienced a decline of six beds used in FY 2009 compared to FY 2005; a 14 percent drop in the number of beds used.

Figure No. 11.



Northwest Region Utilization

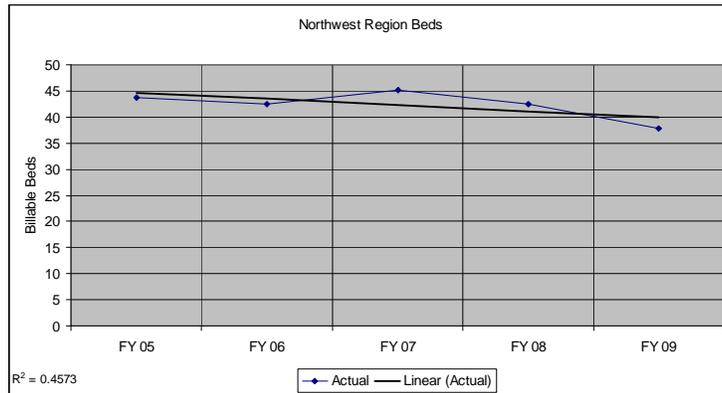
FY 05 Billable Beds: 44

FY 09 Billable Beds: 38

Net Change: -6

Pct. Change: 13.6%

5 Year Trend: Inconsistent/slight downward



Northeast Region

The Northeast Region experienced a decline of 14 billable beds used when comparing FY 2009 to FY 2005. The decline is a nine percent drop in billable beds used in this time period.

Figure No. 12.

Northeast Region Utilization

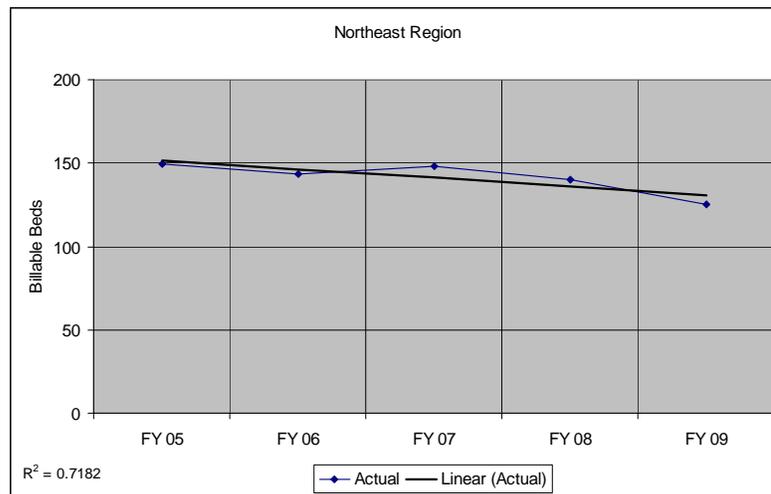
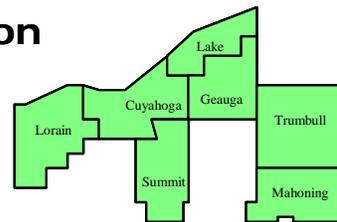
FY 05 Billable Beds: 149

FY 09 Billable Beds: 125

Net Change: -14

Pct. Change: 9.3%

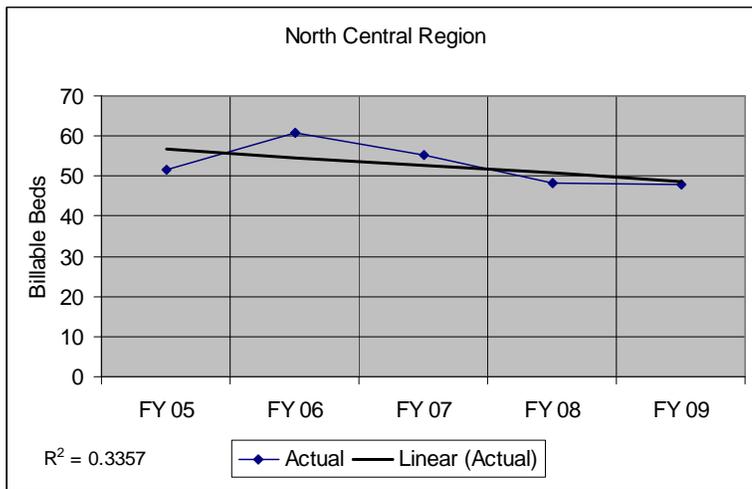
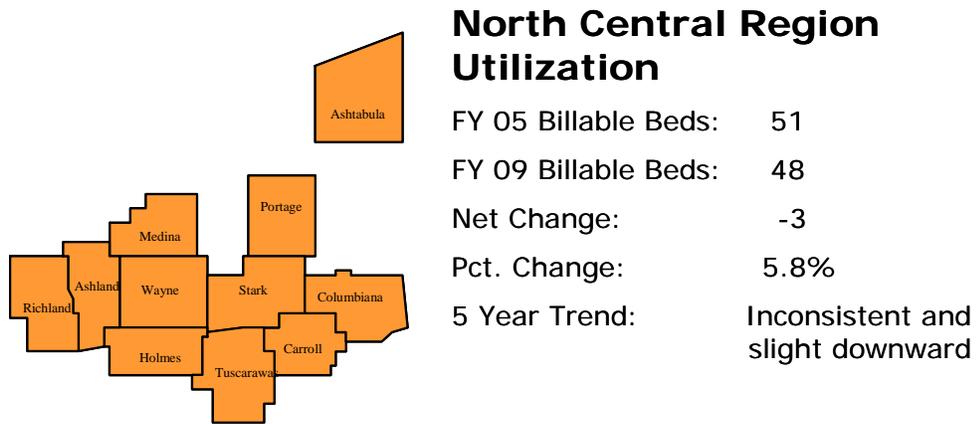
5 Year Trend: Gradual Downward



North Central Region

Comparing FY 2005 to FY 2009, the North Central Region experienced a decline of three beds used, representing a decline of six percent. The five-year trend for the region has been a slight downward movement.

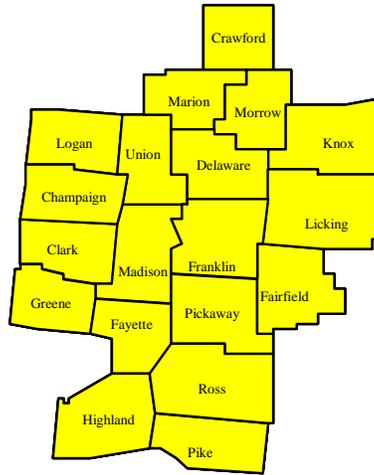
Figure No. 13.



Central Region

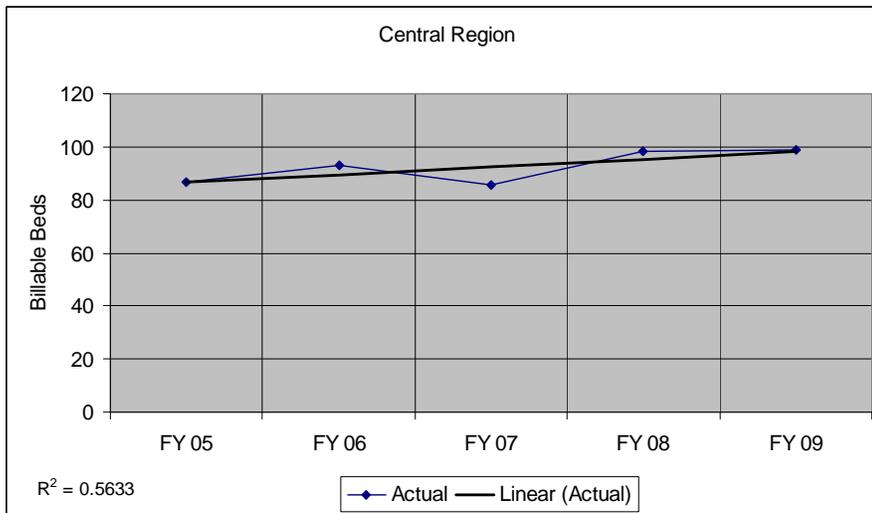
The Central Region is the only region in the state that experienced an increase in the number of billable beds used when comparing FY 2009 to FY 2005. The region used 12 more beds in FY 2009, an increase of 14 percent.

Figure No. 14.



Central Region Utilization

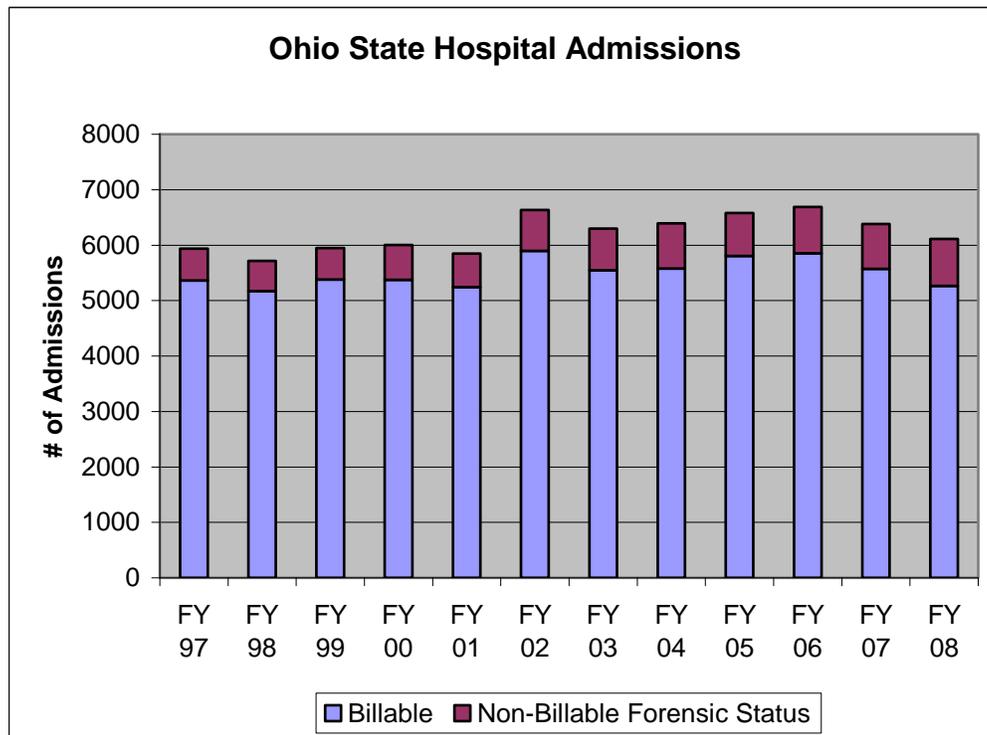
FY 05 Billable Beds:	87
FY 09 Billable Beds:	99
Net Change:	+12
Pct. Change:	13.7%
5 Year Trend:	Inconsistent but gradual Upward



Admissions to State Psychiatric Hospitals

Since 1997, the total number of admissions has increased by three percent. Board billable admissions (which include all civil status and some forensic status admissions) have declined by two percent, but the decline has been more than offset by a 47 percent increase in the number of non-billable forensic status admissions. The past decade though has not been a consistent trend. From 1997 to 2002, admissions increased for both categories and therefore, overall. Billable admissions were up 10 percent, non-billable forensic status admissions were up 28 percent, for an overall increase of 12 percent. Only for the period from 2002 to 2008 has there been the divergence in the number of billable and non-billable admissions. During the past five years, billable admissions have declined by 11 percent while non-billable forensic status admissions increased by 15 percent. The result is that for the past five years, the overall admissions have declined by eight percent. See Figure No. 15 and Table No. 16.

Figure No. 15.



Source: Patient Care System

Table No. 16.

**Ohio State Hospital Admissions
from FY 97 to FY 08**

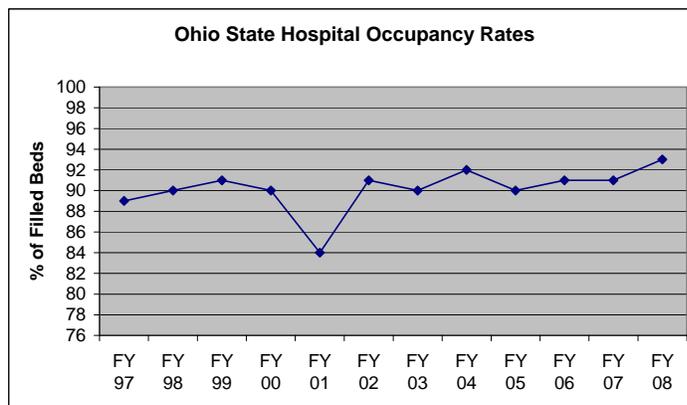
Year	Number of Billable	Pct. Change from Previous Year	Number of Non-Billable (Forensic)	Pct. Change from Previous Year
FY 97	5360	NA	578	N/A
FY 98	5168	-4%	547	-5%
FY 99	5379	4%	570	4%
FY 00	5373	0%	629	10%
FY 01	5241	-2%	604	-4%
FY 02	5896	12%	738	22%
FY 03	5545	-6%	752	2%
FY 04	5575	1%	816	9%
FY 05	5808	4%	773	-5%
FY 06	5855	1%	831	8%
FY 07	5574	-5%	808	-3%
FY 08	5263	-6%	848	5%
FY 97 to 08	Number	Pct. Change	Number	Pct. Change
	-97	-2%	270	47%

Source: ODMH, Patient Care System

Occupancy Rates in State Psychiatric Hospitals

The occupancy rates in the state operated hospitals since 2004 has remained essentially steady. In FY 2004, the rate was 92 percent and then declined a percentage point or so from FY 2005 to FY 2007. In FY 2008, the occupancy rate increased two percentage points to 93 percent, the highest occupancy rate since the data were first tracked in 1997. In FY 2001, the occupancy rate dropped due to these factors: 1) closing of the Cataldi Maximum Security Forensic Unit; 2); opening of new buildings at Heartland and Summit. During the transition of moving the patients, beds on the old and new units were open at the same time, which temporarily impacted the occupancy rate. See Figure No. 17.

Figure No. 17.



Source: Patient Care System

Peak Days

The 2004 report noted that “high occupancy rates have also affected Ohio’s state hospitals in recent years. On average, the daily occupancy rate was 91 percent across all nine state hospital sites during the second quarter of 2004 (April through June).

The baseline information in the 2004 report noted that nearly 36 percent of the state hospital’s days collectively were at peak capacity. That number has fallen; in the second quarter of FY 2009, 25 percent of state hospital bed days were at a peak level of capacity. Peak capacity is defined as any time a hospital’s occupancy rate is 95 percent or higher. Persistently high occupancy rates can have an adverse impact on the availability of beds for acute admissions. The Peak Occupancy Rates, Second Quarter, FY 2009 table summarizes the results for the state hospitals receiving direct acute care admissions. See Figure No. 18.

Figure No. 18.

Peak Occupancy Rates
2nd Quarter, FY 2009

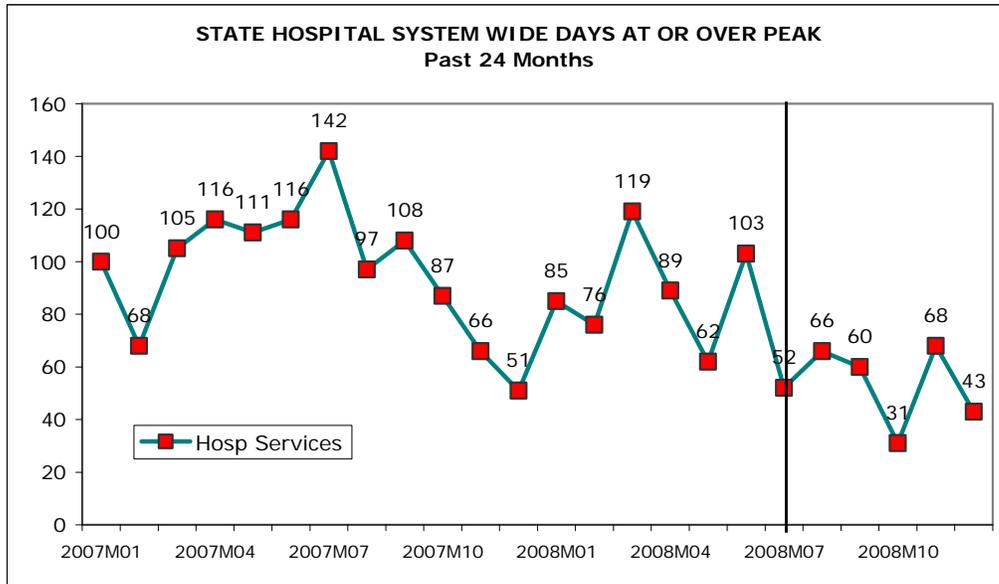
CAMPUS*	Adm	ADRP	Occup. Rate	At or Over Peak Occup.	% of Days At Peak
02_ABH(Athens)	109	73	83%	0	0%
03_TV(Columbus)	200	154	94%	63	68%
05_Summit (Cinti)	81	254	89%	0	0%
06_Heart (Massillon)	129	106	81%	0	0%
07_NBH (Cleveland)	210	93	93%	36	39%
08_NBH (Northfield)	86	165	90%	11	12%
09_NBH (Toledo)	62	93	82%	0	0%
TOTAL	877	938	89%	110	

* On June 30, 2008 Cambridge and Dayton Campuses closed.

The state hospital system-wide peak day trend since 2007 reveals that peak days have fallen significantly in the last year. Reduced peak days are a positive indicator for access within the system, as a whole. This improvement is the result of concerted efforts to reconfigure admission catchment areas among the hospitals to reduce admissions to high occupancy hospitals and increase admissions to relatively low occupancy sites. Further, overflow beds were established at the low occupancy sites to facilitate admissions to the next closest hospital when the local state hospital is at peak occupancy. See Figure No. 19 on next page.

Figure No. 19.

**System Wide Peak Days for All State Hospitals
From January 2007 to December 2008**



Shows the cumulative number of peak days for all state hospitals.
In July, 2008, the number of state hospitals decreased from 9 to 7.

Present Status

On July 1, 2008, two state hospitals were consolidated and the affected 158 beds were redistributed to other ODMH facilities. The decision was in response to Gov. Ted Strickland's order that all state departments had to reduce their current expenses. ODMH took a \$31 million reduction during FY 2008 and early FY 2009.⁵¹ The allocation reduction was due to the projected shortfall of revenue due in large part to the slumping economy felt not only in Ohio, but across the country.

The two facilities closed were the Dayton Campus of Twin Valley Behavioral Healthcare, and the Cambridge Campus of Appalachian Behavioral Healthcare. Although the closing and consolidation of beds of the two locations increased the geographic distance between state-run facilities, a key concern was not to lose any public operated psychiatric capacity in the affected regions. This goal was accomplished by expanding the number of beds at the majority of the remaining seven hospital campuses.

⁵¹ Ohio Office of Budget Management

Private Psychiatric Hospital Beds

State-operated psychiatric beds are only a portion of the array of psychiatric beds available in any state or community. The National Association of State Mental Health Program Directors (NASMHPD) focus group noted that in their 2004 State Profiling System 60 percent of states reporting had experienced a reduction in private psychiatric hospital beds.⁵² The 2004 finding was indicative of a general trend that had occurred nationally resulting in a 43 percent decline of private psychiatric beds per capita in the 10-year period ending FY 2000.⁵³

In the NASMHPD 2005 report, a slight reversal of this trend was occurring nationally. The report noted an increase of 3.5 percent in the number of private psychiatric beds, as well as an increase in the number of admissions. The focus group members discussed that this shift may “suggest that the nature of private psychiatric hospital bed use may also be changing, with more services provided to individuals diagnosed with serious mental illness, individuals who in previous years would more likely have been admitted to state psychiatric hospitals.”⁵⁴

The general hospital specialty unit psychiatric beds have also experienced a shift in numbers. The development of Diagnostic Related Groups (DRG) resulted in an initial marked increase in the number of these beds due to the ability of the hospital to receive full reimbursement for care through a Medicare waiver of financial constraints. Coincidentally or not, when the waiver was dropped, the number of these beds declined. The President’s New Freedom Commission noted a decline of 32 percent in per capita beds nationally.⁵⁵ NASMHPD suggested that general hospital administrations may be choosing to shift “the designation of beds from psychiatric to other, more financially lucrative patients.”⁵⁶

In Ohio, the loss of private and general hospital specialty unit psychiatric beds has continued since 1997. A key factor for the loss of beds during the past decade has been the closure of private psychiatric units. Ohio lost 36 percent of private psychiatric hospitals from 1997 to 2008. The bulk of the loss occurred in the initial five years from 1997 to 2001. Since 2002, the decline in hospitals has leveled off with a loss of only six percent. See Figure No. 20 on the next page.

⁵² Emery, p. 4.

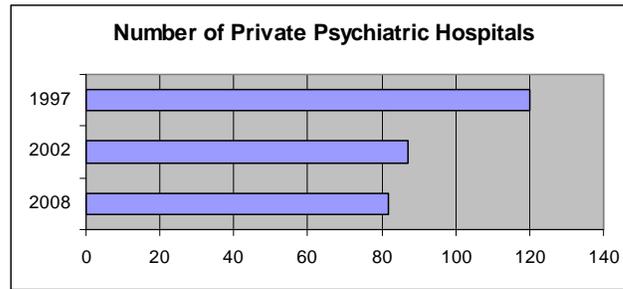
⁵³ *Ibid.*, Emery citing, *President’s New Freedom Commission Subcommittee on Acute Care* report.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ Emery, p. 5.

Figure No. 20.

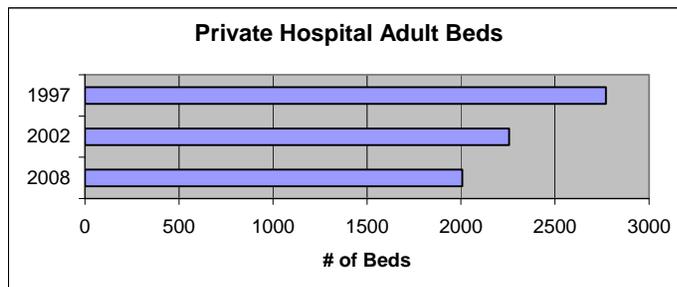


Note: Change from 1997 to 2008: -32%; Change from 2002 to 2008: -6%
Source: ODMH Licensure and Certification

The 2004 Report noted that “Ohio has witnessed a steady decline not only in the number of available private and public hospital beds, but also, in the actual number of psychiatric hospitals or hospital psychiatric units. For the years 1997 through 2002, 13 private psychiatric units closed representing an 18 percent decrease in beds from 3,456 to 2,842. The decline in availability of private beds was a trend seen across all age categories: adults (16 percent), adolescents (28 percent) and children (13 percent).”⁵⁷ The 2004 report also noted that “between 1989 and 1996, Ohio closed its two public children’s hospitals, one adolescent center (the state no longer provides public inpatient psychiatric care for children and adolescents), and three adult facilities. Public beds for Ohio, between 1997 and 2002, were reduced by 21 percent from 1444 to 1146.”⁵⁸

The experience in Ohio since 2002 to present reveals that while the decline in public and private adult and adolescent beds has continued, the rate of decline has decelerated. For adult beds, the change from 1997 to 2008 is a total decline of 28 percent. The change over the past six years, has accounted for an 11 percent decline. See Figure No. 21.

Figure No. 21.



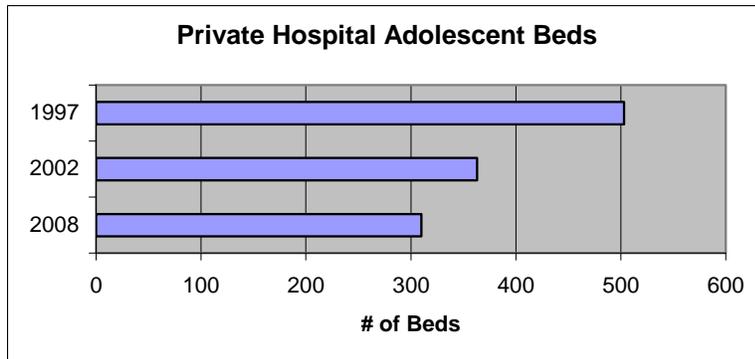
Note: Change from 1997 to 2008: -28%; Change from 2002 to 2008: - 11%
Source: ODMH Licensure and Certification

⁵⁷ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 5.

⁵⁸ Ibid.

Adolescent beds have experienced an even greater decline. The decline in adolescent beds dropped 38 percent since 1997. As with adult beds, the greater drop occurred in the first half of the decade, with there being only a 15 percent decline from 2002 to 2008. See Figure No. 22.

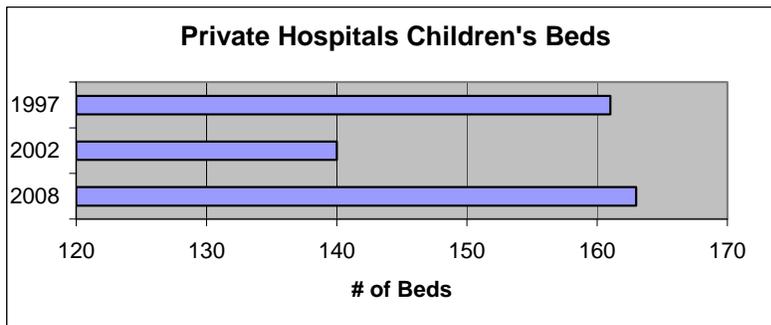
Figure No. 22.



Note: Change from 1997 to 2008: -38%; Change from 2002 to 2008: -15%
Source: ODMH Licensure and Certification

The number of beds for children has bucked the trend of adult and adolescent beds. There was a thirteen percent decrease in children's beds from 1997 to 2002. However, over the past six years, all of the lost beds were recouped with a couple more added in. See Figure No. 23 on the following page.

Figure No. 23.



Note: Change from 1997 to 2008: +1%; Change from 2002 to 2008: +16%
Source: ODMH Licensure and Certification

REGIONAL DIFFERENCES IN THE STATE

The experience throughout Ohio is not homogenous. There are significant variations across regions. Regarding the state hospital beds, in 2010 there are now seven state hospitals strategically placed geographically across six regions in the state. The six regions are: Northeast with two hospital campuses, and Northwest, Southwest, North Central, Central, and Southeast with one hospital each. The new regional configuration and the psychiatric beds in each is shown on the following charts.

Variance exists across the regions in terms of the number of state hospital beds per 100,000 in population. The Southwest Region has the highest number of state hospital beds per 100,000 population at 17.4. The Central and Northwest Regions have the fewest number of state hospital beds per 100,000 population with 9.4 and 9.5 beds, respectively. The Central Region has 46 percent fewer beds per 100,000 population than the Southwest Region. See Figure No. 24. Note: the rate per 100,000 population is based on the 2000 census. Thus, all of these rates are likely somewhat different given the uneven growth throughout the state.⁵⁹ For example, an analysis of the larger counties in the state, according to the U.S. Census Bureau, Franklin County continues to experience robust growth of 4.5 percent from 2000 to 2007. At the same time, Cuyahoga County is continuing to decline in population. From 2000 to 2007, the population is estimated to have declined by seven percent. Hamilton, Lucas, Mahoning and Montgomery Counties are estimated to have slight declines in their populations. Summit and Stark Counties are estimated to have experienced slight increases.⁶⁰

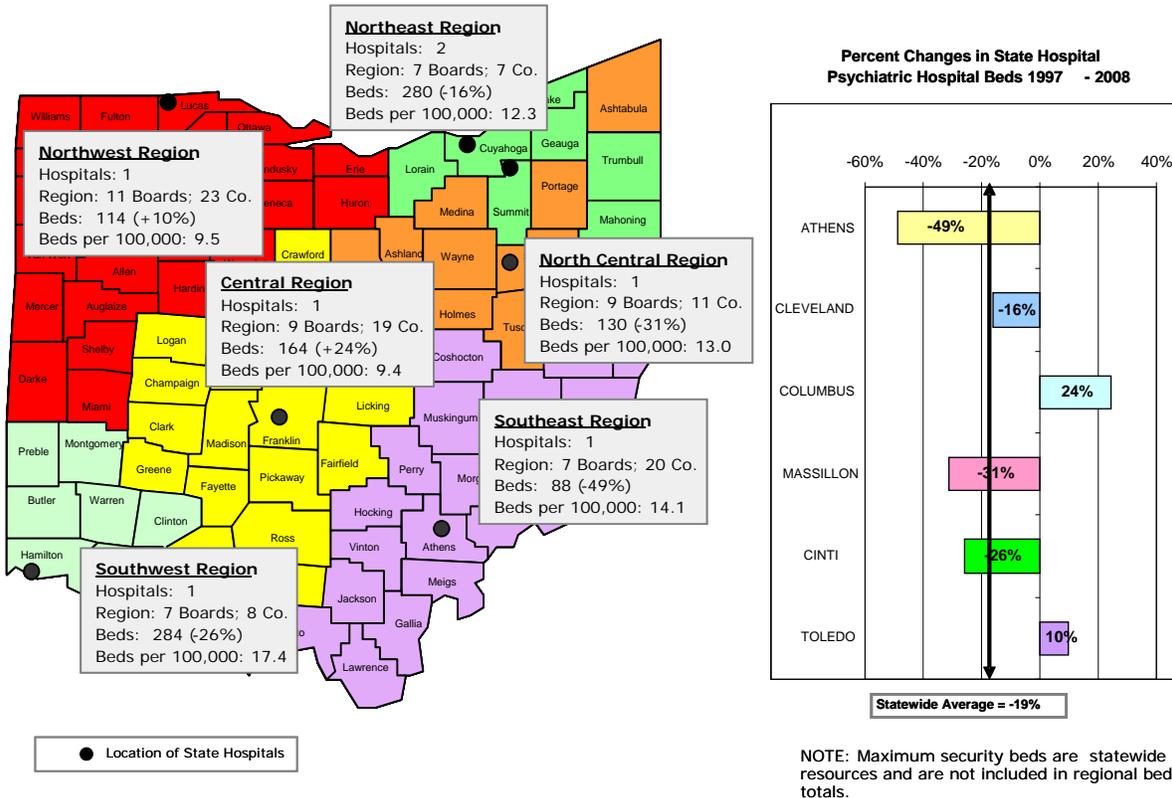
The consolidation of campuses and has resulted in shifting of beds across regions. The Southeast Region experienced the largest shift losing 49 percent of its state hospital beds since 1997. The least shifting of beds occurred in the Northwest Region which gained 10 percent of its state hospital beds during the past decade. The statewide average has been a 19 percent decrease in the number of state hospital beds. See Figure No. 24 on next page. The Central Region experienced the greatest gain in percentage of state hospital beds at 24 percent. Despite this gain, the Central Region still has the lowest number of state hospital beds per 100,000 population. A key reason is the Central Region continues to experience population growth at a greater rate than the other areas of the state.

⁵⁹ U.S. Census Bureau, Population Division, *Annual Estimates of the Populations for the Counties of Ohio: April 1, 2000 to July 1, 2007*, Co-Est 2007-01-39. Release Date: March 20, 2008.

⁶⁰ Ibid.

Figure No. 24.

State of Ohio State Psychiatric Hospital Adult Bed Analysis

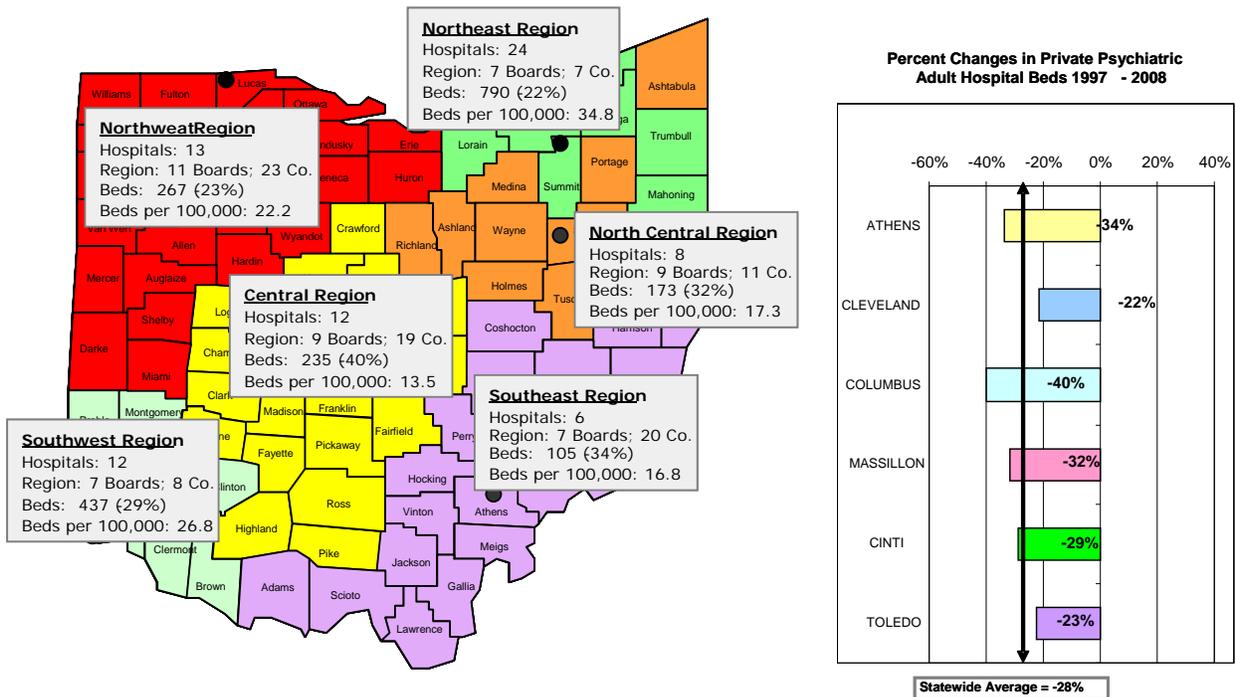


In terms of adult private psychiatric beds, there exists a similar variance across the six regions. The Northeast and Southwest Regions have the highest number of adult private psychiatric beds per 100,000 population at 34.8 and 26.8 beds, respectively. At the other end of the spectrum, the Central Region has the lowest number of adult private psychiatric beds per 100,000 populations at 13.5 beds. Note: the rate per 100,000 populations is based on the 2000 census. Thus, all of these rates are likely to be somewhat different given the uneven growth throughout the state over the past nine years. Likely, the Central region rate is even lower in light of the continued estimated population growth in the Central Ohio area. The rates for the Northeast and Southwest Regions may be slightly higher based on the estimated slight decreases in population in those areas of the state. See figure No. 25 on next page. The disparity between the Central Region and the Northeast Region in terms of beds per 100,000 population is 61 percent fewer beds. Compared to the Southwest region, the Central region has 49 percent fewer beds.

During the past decade, all the regions have experienced a drop in the number of adult private psychiatric beds. The decline has been substantial in all regions with the average decline of 28 percent. The Central Region experienced the greatest decline at 40 percent. The Northeast Region experienced the lowest percentage of decline at 22 percent. See Figure No. 25.

Figure No. 25.

State of Ohio Private Psychiatric Adult Bed Analysis



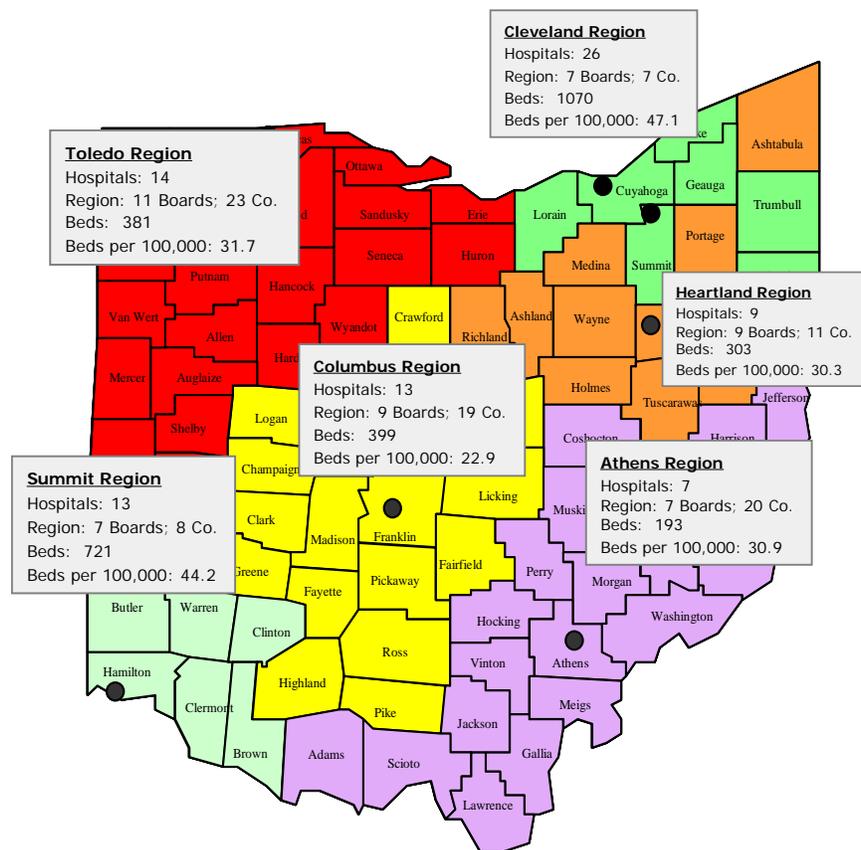
NOTE: Beds per 100,000 is calculated on adult census figures from 2000.

Combination of State and Private Psychiatric Hospital Beds

The comparison of the combination of state hospital and private hospitals adult beds reveals that the Northeast and Southwest Regions are close to the 50 beds per 100,000 population recommended by the TAC. The Northeast Region has a combined total of 47.1 adult beds per 100,000 population and the Southwest Region has 44.2 beds. As could be surmised from the previous discussion, the Central Region has the lowest number of beds per 100,000 with 22.9 beds. Overall, the Central Region has nearly one-half the beds per 100,000 population as do the Northeast and Southwest Regions. The remaining three regions are clustered in the middle and very close to one another with the Northwest region having 31.7 beds, the Southeast Region with 30.9 beds and the North Central Region with 30.3 beds. See Figure No. 26.

Figure No. 26.

State and Private Psychiatric Hospital Beds Combined

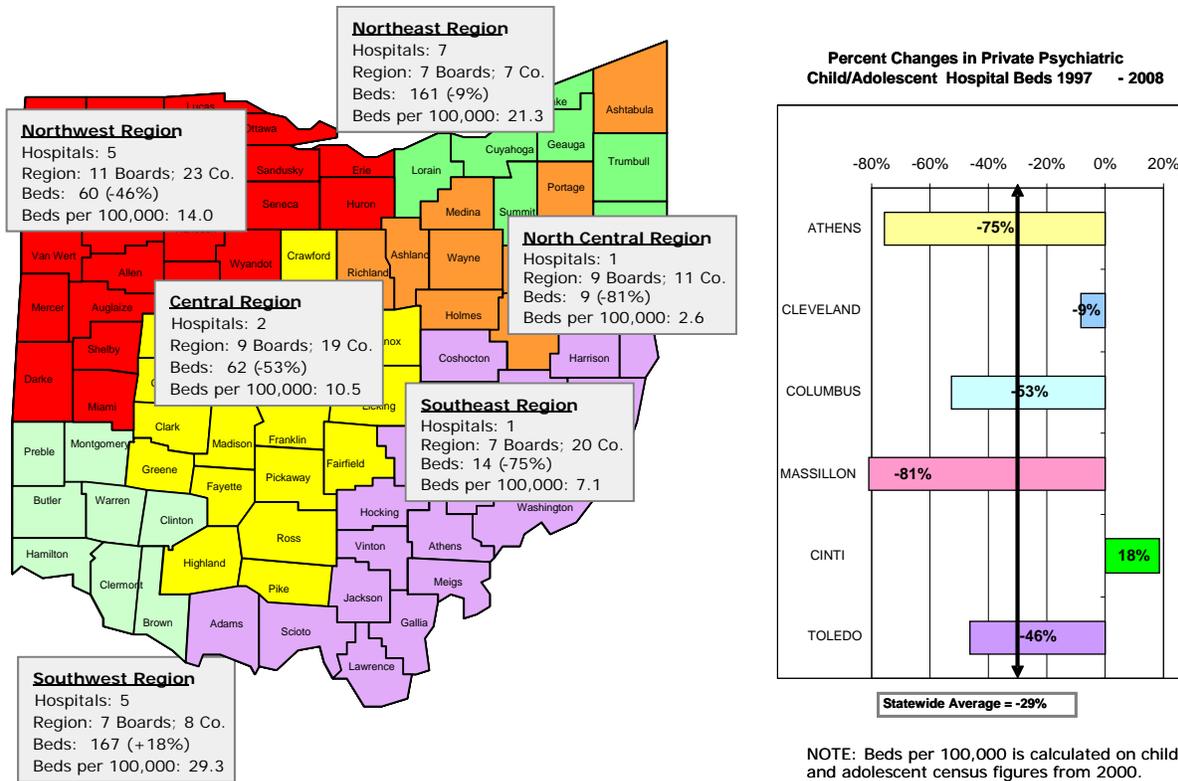


Child and Adolescent Beds

Though the thrust of this updated report is primarily on adult inpatient services, the child and adolescent bed changes are important considerations. ODMH has not operated any child or adolescent inpatient programs for nearly two decades. All inpatient services for these populations are provided by private inpatient providers. Over the past decade, only the Southwest Region experienced a net increase in the number of adolescent and child beds with an increase of 18 percent. Especially hard hit were the Central, Southeast and North Central Regions losing 53 percent, 76 percent and 81 percent of these beds, respectively. The result is that the Southwest Region has the highest rate of beds at 29.3 beds per 100,000 child and adolescent population. The North Central Region has the lowest rate with only 2.6 beds per 100,000 population. See Figure No. 27.

Figure No. 27.

State of Ohio Private Psychiatric Child and Adolescent Bed Analysis



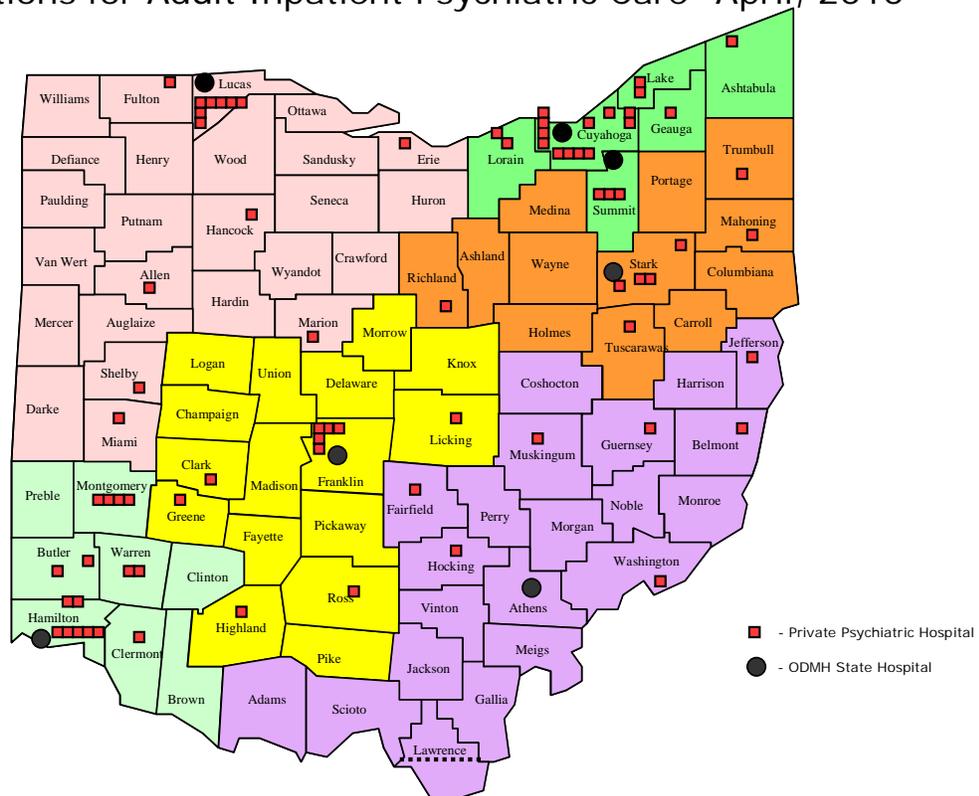
Geographic Proximity

Ever mindful that geographic proximity is an important aspect of access to services, an initial analysis studied whether an inpatient facility was within 60 miles (or roughly an hour travel time) of every Ohioan. The analysis determined that an inpatient psychiatric facility is within 60 miles of nearly all areas of the state; the exception being the southern half of Lawrence County along the Ohio River, indicated by the dotted line in figure No. 28. The areas beyond the 60-mile radius are highlighted by the dash mark line. Figure No. 28 also depicts the approximate locations of the inpatient psychiatric facilities in Ohio as of April, 2010. Note: for clarity, the hospitals in the urban centers are depicted in rows rather than their precise placement in the county.

Figure No. 28.

Sixty Mile Radius from an Inpatient Adult Psychiatric Facility

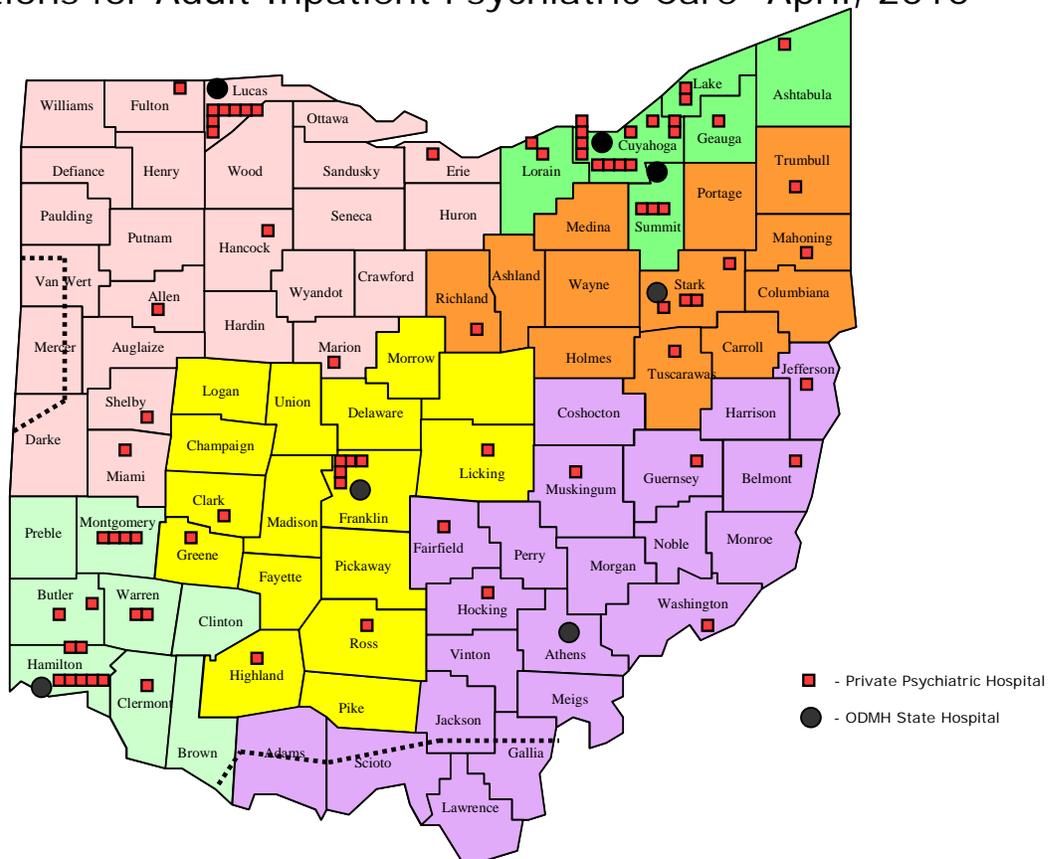
Locations for Adult Inpatient Psychiatric Care- April, 2010



Another analysis was conducted to determine whether an inpatient psychiatric or crisis facility, public or private, was within 30 miles (or roughly a 45-minute travel time) of every Ohioan. This analysis determined that while most areas of the state still remain within 30 miles of an inpatient or crisis facility, there are several gaps in the geographic coverage: the extreme south central border including all of Lawrence County and significant portions of Jackson, Gallia, Scioto and Adams counties; and portions of the central western border including parts of Darke, Mercer and Van Wert counties. See Figure No. 29. The areas beyond the 30-mile radius are highlighted by the dash mark line.

Figure No. 29.

Thirty Mile Radius of an Inpatient Psychiatric Facility
Locations for Adult Inpatient Psychiatric Care- April, 2010



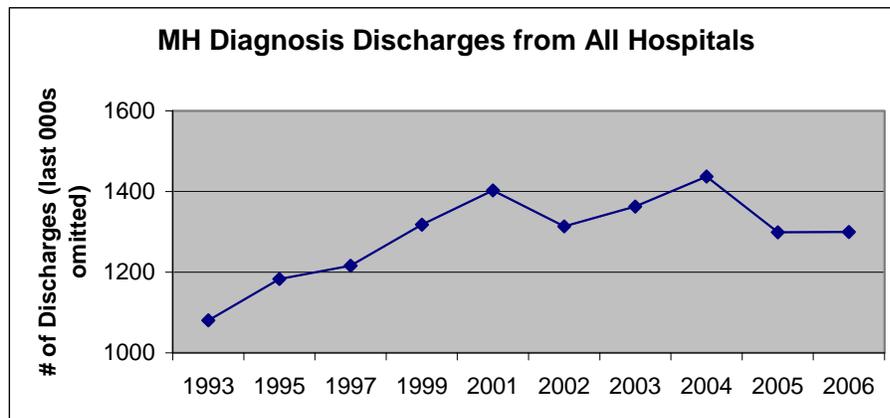
Admissions and Lengths of Stay

The number of beds is one issue. Equally important, and directly related to occupancy rates and peak periods, are data on admissions and length of stay.

The 2004 Report noted that “according to the National Association of Psychiatric Health Systems (NAPHS), admissions to private psychiatric hospitals and psychiatric units in general hospitals have increased by three to four percent annually.”⁶¹ The NAPHS 2007 survey of its 600 member hospitals indicated that the increase in admission trend continues at a similar rate. For the years 2005 and 2006, the private psychiatric hospitals experienced a 3.4 percent increase in admissions.⁶²

The 2004 Report noted that “for the nine-year period, 1993 through 2001, data from the Agency for Healthcare Research and Quality’s National Inpatient Database, the largest all-payer inpatient care database in the United States containing information from approximately seven million hospital stays, documented an increase of 29 percent in the number of patients being discharged with a primary mental health diagnosis.”⁶³ The Agency for Healthcare Research and Quality’s National Inpatient Database noted that for the more recent period of 2002 to 2007, there was a slight decrease in 2002 and 2003. The number of discharges spiked again in 2004, and then declined slightly again and now appears to be leveling off.⁶⁴ See Figure No. 30

Figure No. 30.



Note: Last three digits in number of discharges are omitted. Data is rounded to nearest thousandth.

Source: Agency for Healthcare Research and Quality (AHRQ)

⁶¹ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 10.

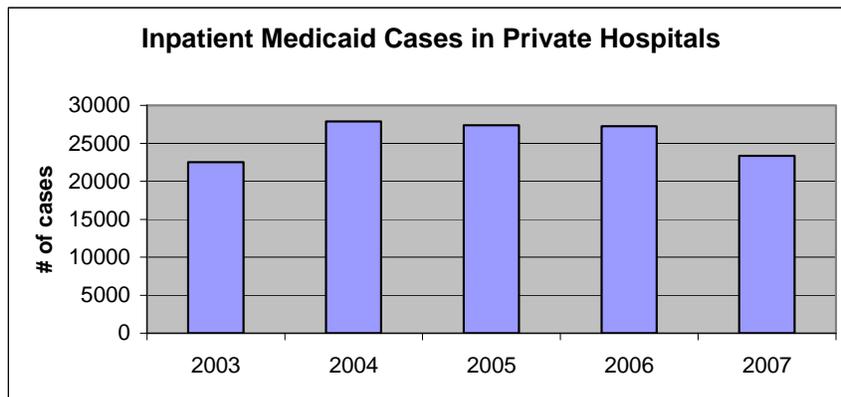
⁶² “New NAPHS Annual Survey Tracks Behavioral Treatment Trends,” *National Association of Psychiatric Healthcare Systems 2007 Annual Survey*, press release, May 16, 2008.

⁶³ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 10.

⁶⁴ Agency for Healthcare Research and Quality’s National Inpatient Database, MDC 19 Discharges 1993 to 2007.

The 2004 Report noted that “Ohio has also experienced similar increases in the numbers of admissions and discharges across both its private and public sectors. Patients discharged from all private Ohio hospitals with a major diagnostic category of mental illness increased 3.5 percent between 2000 and 2002 from 75,310 (529,953 bed/days) to 77,912 (528,584 bed/days). Ohio Medicaid patients receiving inpatient psychiatric care grew by nearly 30 percent over the five-year period of time from 1999 through 2003 from 17,339 to 22,500.”⁶⁵ An updated analysis shows that the number of patients receiving inpatient care either paid by Medicaid or managed-care Medicaid increased to 27,877 in 2004. For the next two years, that number remained essentially the same, until 2007 when the number declined to 23,359, or 14 percent.⁶⁶ A conjectured explanation is that managed psychiatric care is experiencing the similar reduction in use as other inpatient health care. See Figure No. 31.

Figure No. 31.



Source: Ohio Hospital Association, MI by Payer Spreadsheet, August, 2008 and *The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem*, April, 2004.

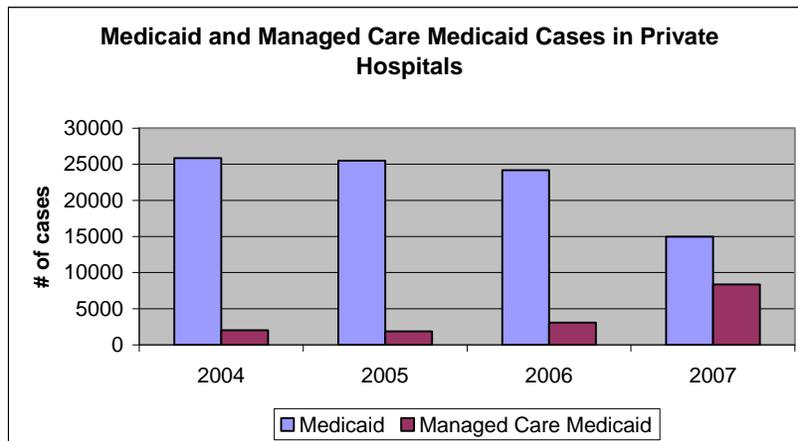
During the past four years, the number of patients with non-managed care Medicaid has declined, while the number with managed-care Medicaid has increased. In 2004, Managed-care Medicaid comprised only seven percent of the inpatient Medicaid cases. By 2007, managed-care Medicaid had grown to comprise 36 percent of inpatient psychiatric Medicaid cases.⁶⁷ See Figure No. 32 on next page.

⁶⁵ *The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 10.

⁶⁶ Ohio Hospital Association, OHA Statewide Clinical and Financial Database, August, 2008.

⁶⁷ Ibid.

Figure No. 32.

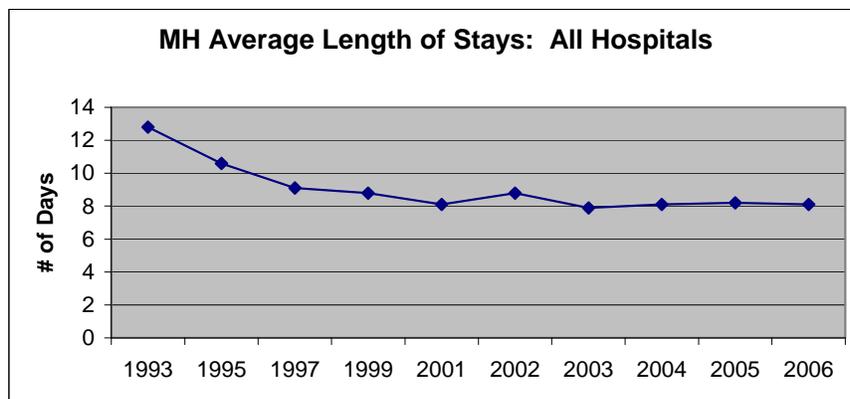


Source: Ohio Hospital Association, MI by Payer Spreadsheet, August, 2008

Length of Stay

The National Association of Psychiatric Healthcare Systems noted in their 2007 survey that the “lengths of stay remained steady at 9.6 days in both 2005 and 2006.”⁶⁸ The Agency for Healthcare Research and Quality’s National Inpatient Database noted that the average length of stay for all mental health Major Diagnostic Categories (MDC) remained essentially unchanged with only minor fluctuations from 2001 to 2007. This finding is disparate with the finding noted in the 2004 Report for the period from 1993 to 2001, wherein the average length of stay declined by 37 percent from 12.8 days in 1993 to 8.1 days in 2001.⁶⁹ Since 2001, the average length of stay in all hospitals for mental health diagnoses has remained relatively constant around eight days.

See Figure No. 33.



Source: Agency for Healthcare Research and Quality

⁶⁸ | New NAPHS Annual Survey Tracks Behavioral Treatment Trends,” *National Association of Psychiatric Healthcare Systems 2007 Annual Survey*, press release, May 16, 2008.

⁶⁹ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 10.

In Ohio, the 2004 Report noted there was a 9.9 percent decline in the average length of stay for Medicaid patients discharged from psychiatric units in general hospitals from 1999 to 2003. The data for the more recent period 2004 to 2007 indicates the average length of stay has remained reasonably constant, fluctuating only slightly between 6.3 and 6.2 days for Medicaid-only patients. For patients who are covered under managed-care Medicaid, the average length of stay was 4.4 days in 2004 and gradually climbed to 5.0 days in 2007.⁷⁰

The 2004 Report noted that data furnished by the Ohio Hospital Association “indicates that inpatient stays for all Ohio patients discharged with a primary mental health diagnosis fell three percent, from 7.0 to 6.8 days between 2001 and 2003.”⁷¹ The Ohio Hospital Association data since then indicates a drop in 2004 to 6.0 days. Since 2004, the average length of stay has fluctuated only slightly. For 2007, the average length of stay was 5.7 days.⁷²

The 2004 Report indicated that “in Ohio’s state hospitals, length of stay has followed national and state trends. Approximately, three-fourths of the patients served tend to be acute with a median length of stay of nine days. While the number of acute care patients has increased prominently in recent years, there has been a marked reduction in the number of long-term patients, defined as patients with a length of stay greater than 45 days. Since 1998 the long term bed days have fallen by over 60 percent.”⁷³

⁷⁰ Ohio Hospital Association, OHA Statewide Clinical and Financial Database, August, 2008.

⁷¹ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004

⁷² Ohio Hospital Association, OHA Statewide Clinical and Financial Database, August, 2008.

⁷³ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004.

Part II Access and Capacity of Ohio's Inpatient System Key Points

- 1) The Ohio public and private inpatient system continues to lose inpatient beds across the system. Ohio's experience generally mirrors the national trend. The rate of the decline in the number of available beds has leveled off in the past four years compared to the previous period. The leveling effect in the number of inpatient beds may indicate a tenuous stability in the pool of available beds. The primary area of the decline of beds has been in the private hospital sector. Despite the closure of two state hospital campuses, the state hospital system's net number of beds remained stable with increases in capacity developed at the remaining hospitals.
- 2) In determining the ideal or baseline number of beds needed, more work is needed to arrive at this amount. The Treatment Advocacy Center posited 50 beds per 100,000 population was needed across the country. However, the TAC-recommended ratio of beds per population does not address regional, state and even intrastate variations in need. Many factors must be evaluated, including: the community support system and its ability to sustain patients locally; wait times in pre-screening or emergency departments; occupancy rates; number of admission refusals; number of homeless persons with a serious mental illness that puts them at risk for injury to self or others; and the number of incarcerated persons in county jails and prisons who have a serious mental illness that qualifies for inpatient level of care.
- 3) There is regional variability in terms of the number of beds available in Ohio. The Northeast and Southwest regions of the state have the higher ratio of beds per population. The Central and Southeast regions have the lower ratio of beds per population. These regional differences must be considered in determining the overall needed inpatient capacity.
- 4) Nationally, the average length of stay has leveled off during the past four years at around eight days. For the private hospitals in Ohio, the average length of stay is below the national average and has declined slightly over the past four years. In the state hospitals, the median length of stay for civil status patients has increased slightly from 12 to 14 days. With the stability in the average lengths of stay, the key variables impacting bed capacity and access will be the number of admission referrals and the complex and/or resistant-to-progress cases that become outliers, whose lengths of stay are significantly longer than the average.
- 5) Within the state hospital system, the number of civil bed days paid for by the ADAMH Boards continues to decline. The decline is primarily attributed to the decreased length of stay. The trend line forecast is that the decline in the number civil bed days will continue and may result in a decline of 8,900 bed days by FY 2012. The 8,900 bed days would translate into a decreased need for 24 civil beds in the state hospital system. The forecasted decline in need of civil beds may or may not translate into increased bed capacity. In Part III we will examine the forensic bed situation that may impact on any bed capacity achieved from the decline in the civil bed days.

Part III

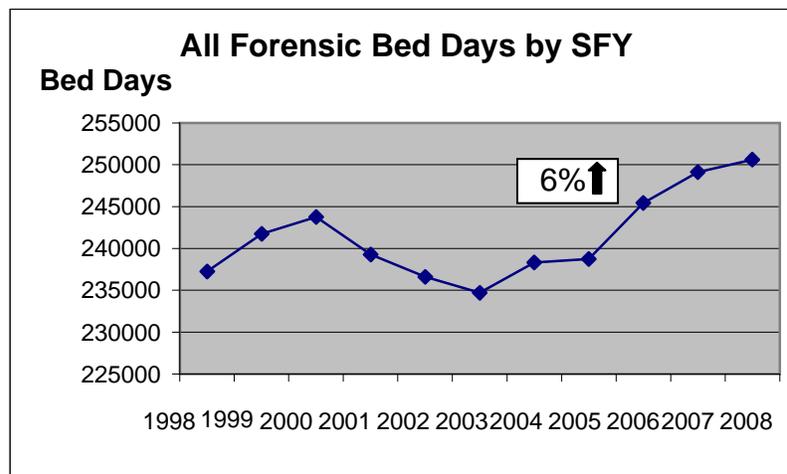
Forensic Inpatient Psychiatric Services by Ohio's Public Mental Health System

Part III

Forensic Inpatient Psychiatric Services by Ohio's Public Mental Health System

Forensic status patients are increasingly occupying a greater percentage of the available inpatient beds at Ohio's state operated psychiatric hospitals. From 1998 to 2008, an increase of nearly six percent was seen across the system in total forensic bed days. The forensic bed days dropped between 2000 and 2003. However from 2003 to 2008, the bed days increased by nearly seven percent. See Figure No. 34.

Figure No. 34



Source: ODMH, Patient Care System

Note: Senate Bill 285 was effective 7/1/97 which changed the management of certain forensic status patients and the fiscal responsibility for their inpatient care.

Upon initial examination, this increase over the past decade may seem modest. However, greater analysis within the increased numbers reveals an 18 percent increase in the non-billable forensic bed days, while the billable forensic bed days declined by 31 percent. Billable forensic bed days are bed days consumed by patients who are hospitalized under the following forensic statuses that are paid by the patient's ADAMH/CMH board:

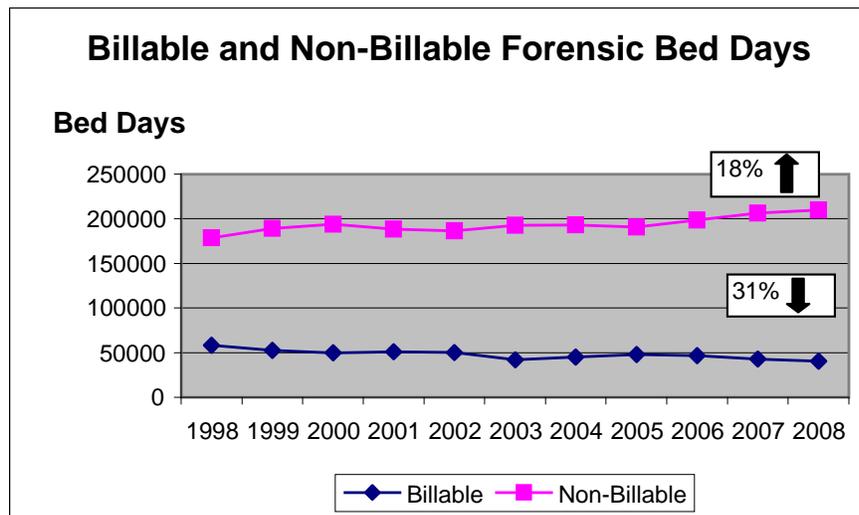
- 1) Incompetent to Stand Trial-Unrestorable (IST-U) probate court jurisdiction (ORC 2945.38 (H)(4));

- 2) Incompetent to Stand Trial Restoration (IST_R) treatment to competency and in the hospital to maintain competency (ORC (2945.38 A);
- 3) Parolee and Probationer (ORC 2967.22);
- 4) Jail Transfers and Police Holds (Applicable ORC 5122. section);
- 5) Sanity and Competency Evaluations (ORC 2945.371)

Non-billable forensic bed days are bed days used by patients who are hospitalized under the following forensic statuses that results in the bed days being paid by ODMH and not by the ADAMH/CMH Boards:

- 1) Not Guilty by Reason of Insanity (NGRI) (ORC 2945.40; 2945.402);
- 2) Incompetent to Stand Trial, Unrestorable, under criminal court jurisdiction (IST-U-CJ) (ORC 2945.39);
- 3) Incompetent to Stand Trial, but Restorable (ORC 2945.38 (b));
- 4) Not Guilty by Reason of Insanity and on conditional release or Incompetent to Stand trial, Unrestorable, under criminal court jurisdiction (IST-U-CJ) and on conditional release (ORC 2945.402).

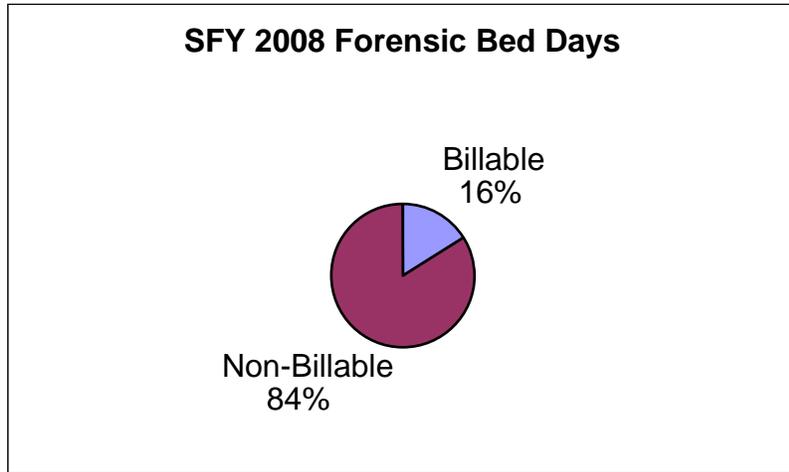
See Figure No. 35.



Source: ODMH, Patient Care Systems

In 2008 non-billable bed days made up 84 percent of all the forensic bed days. See Figure No. 36 on the next page.

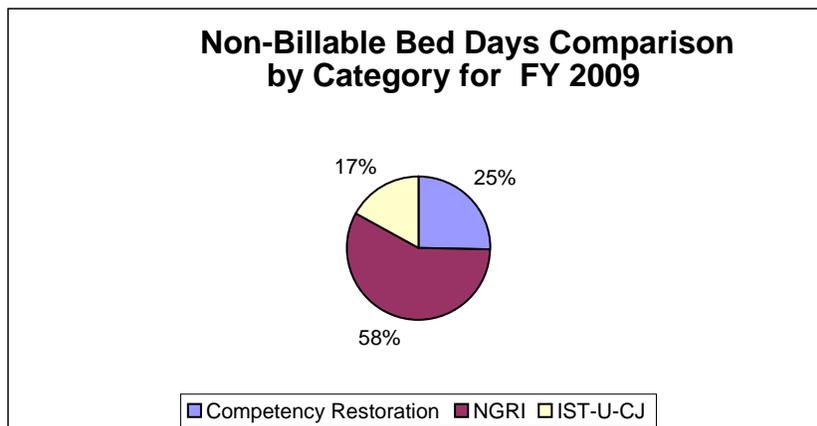
Figure No. 36.



Source: ODMH, Patient Care System

The Not Guilty by Reason of Insanity patients comprise the larger percentage (58 percent) of the non-billable bed days use compared to the Incompetent to Stand Trial and sent for restoration (25 percent) and the Incompetent to Stand Trial and not likely to be restored with criminal court jurisdiction (17 percent). See Figure No. 37.

Figure No. 37.



Source: ODMH Patient Care System

The non-billable forensic patients are more likely to have extended length of stays. For example, in FY 2008, the non-billable forensic status patients had the longest median length of stay (92 days) in comparison to the other patient categories: acute care and long term care. See Figure No. 38.

Figure No. 38.

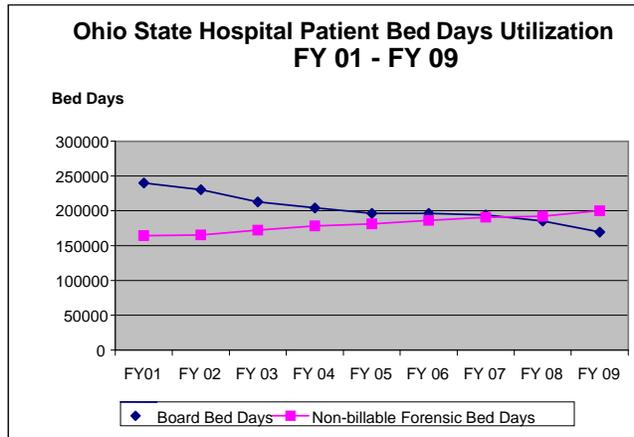
A Profile of Ohio State Hospital Patients FY 2008

Patient Category	Number of Patient Discharges	Percent of Patients	Median Length of Stay
Acute (≤ 45 days)	4588	74%	12
Long Term (> 46 days)	762	12%	80
Non-Billable Forensics	852	14%	92

Data from FY 2008. Acute and long term groups include all patients billable to local Mental Health Boards, including some with forensic legal statuses.

The impact of the increased length of stay of the non-billable forensic patients on bed day use is indicated by the following utilization trend. While billable bed days have declined 29 percent from FY 2001 to FY 2009, the non-billable forensic bed days have increased by 22 percent over the same period of time. A comparison of FY 2008 to FY 2009 indicates a continuation of these converse trends. While the board bed days declined 8.5 percent from FY 2008 to FY 2009, the non-billable forensic bed days increased by 4.1 percent. See Figure No. 39 on the next page.

Figure No. 39.

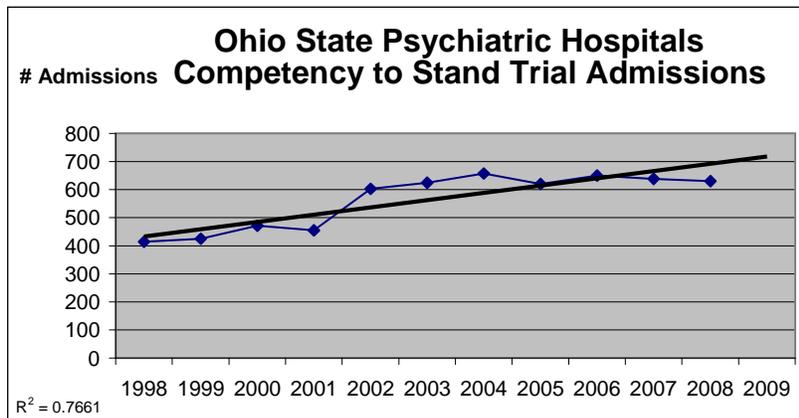


Source: ODMH, Patient Care System

Since 1998, the two primary categories of non-billable forensic bed days: Restoration to Competency and Not Guilty by Reason of Insanity, have seen an increase in the number of admissions, 52 percent and 59 percent respectively.⁷⁴ The linear upward trend is especially strong for the Restoration to Competency admissions. The Not Guilty by Reason of Insanity admission trend is less consistent, but nevertheless shows a moderate trend upward, especially over the past five years. See figures No. 40 and 41.

Figure No. 40.

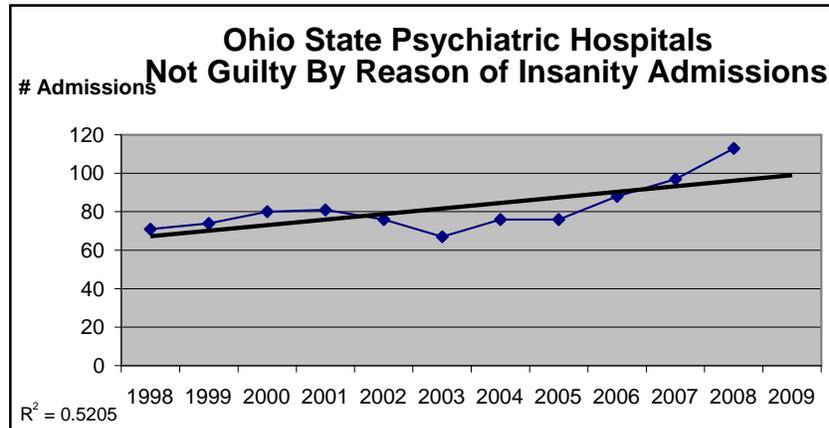
Ohio State Psychiatric Hospitals
Competency to Stand Trial Admissions with Trend Line



Source: ODMH, Patient Care System, Admissions by Legal Status Group Report, 2009.

⁷⁴ Patient Care System Report, *Admissions Trends by Legal Status Group*, Ohio Department of Mental Health, October, 2008.

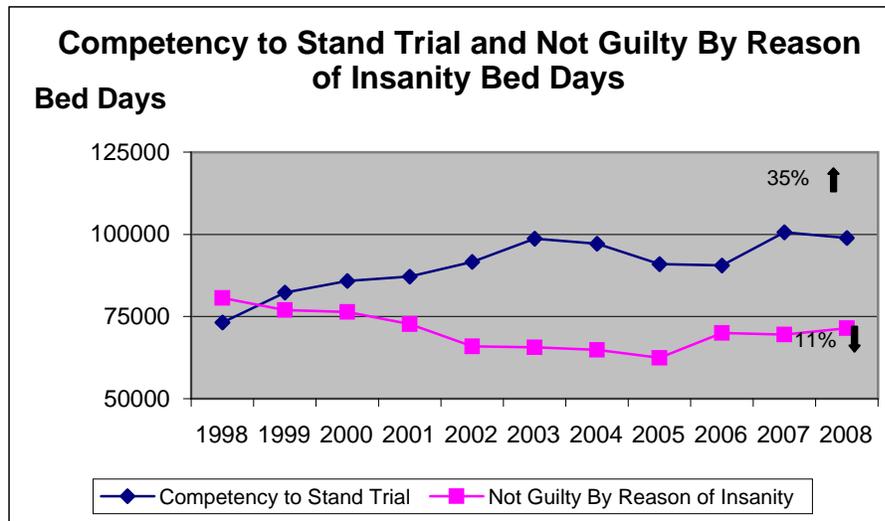
Figure No. 41.



Source: ODMH, Patient Care System, Admissions by Legal Status Group Report, 2009.

Regarding actual bed days used for these two non-billable legal statuses, the Restoration to Competency legal status has shown a 35 percent increase over past 11 years, while the Not Guilty by Reason of Insanity legal status bed days has declined by 11 percent. See Figure No. 42.

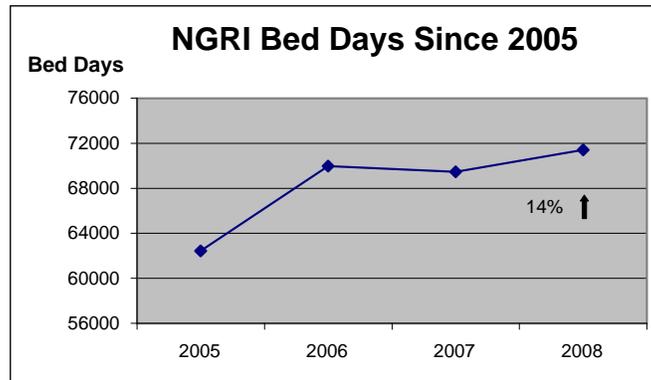
Figure No. 42.



Source: ODMH, Patient Care System

Further analysis of the Not Guilty by Reason of Insanity legal status reveals, however, that since 2005, there has been a steady increase in bed days to where the 2008 bed day use represented a 14 percent increase over the past four years.⁷⁵ See Figure No. 43.

Figure No. 43.

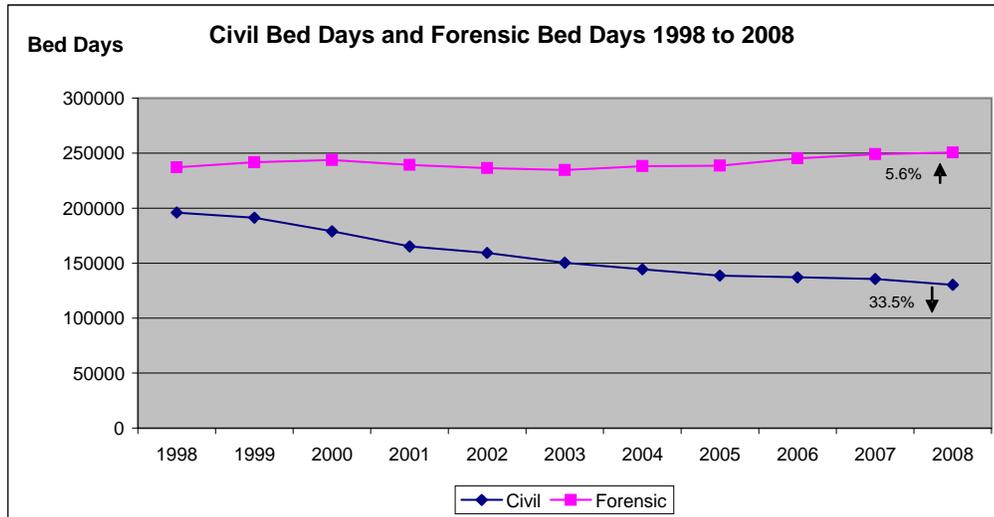


Source: ODMH, Patient Care System

The net result is a gradual, but persistent increase in the total percentage of overall beds days that are consumed by forensic clients, billable and non-billable. Since 1998, while forensic bed days increased nearly six percent, civil bed days declined by nearly 34 percent. See Figure No. 44 on the next page.

⁷⁵ Ibid.

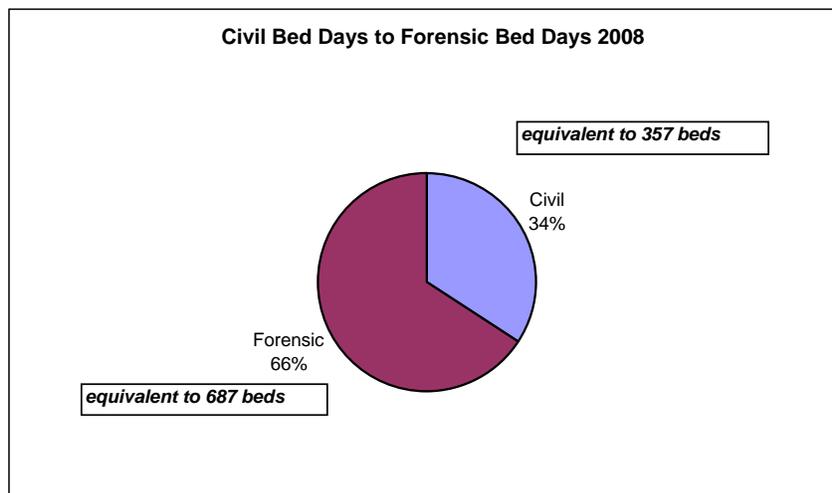
Figure No. 44.



Source: ODMH, Patient Care System

The net result is that in 2008, forensic bed days comprised two-thirds of all bed days consumed across the system. See Figure No. 45.

Figure No. 45.



Source: ODMH, Patient Care System

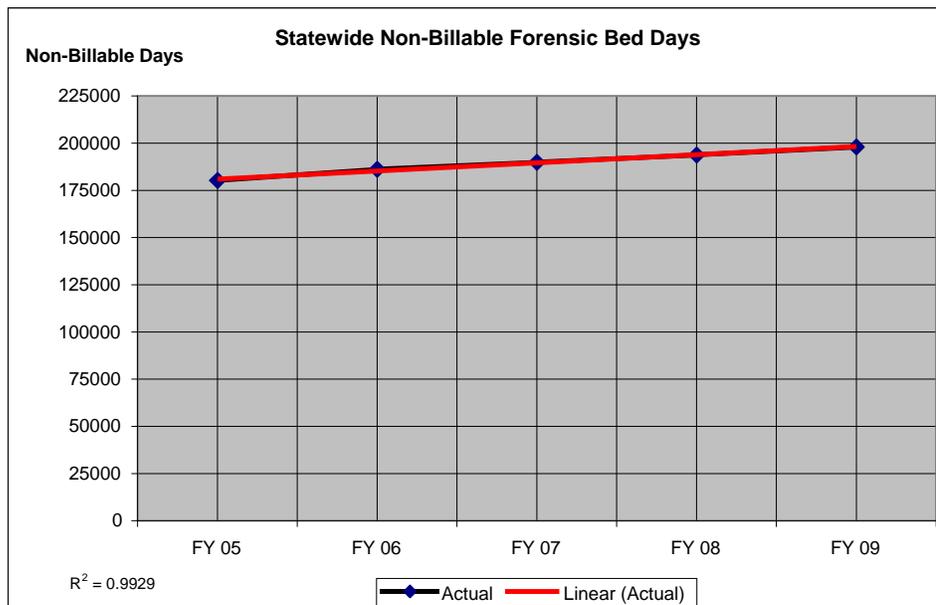
There may be several factors that account for this development:

- 1) Increase in the number of admissions of patients determined to be incompetent to stand trial and in need of treatment and competency restoration services.
- 2) Increase in the number of forensic status patients with length of stays in excess of one year.
- 3) Legislative changes in SB 285 that allowed patients who were found to be unrestorable to competency to stand trial on violent first or second degree felonies. Whereas they formerly were committed to the state hospital by the Probate Court (billable status), they were now to be committed by the Criminal Court under a forensic (non-billable) status.

Non-Billable Forensic Bed Days

The non-billable forensic bed days reflects a consistent upward trend from FY 2005 to FY 2009. See Figure No. 46.

Figure No. 46.

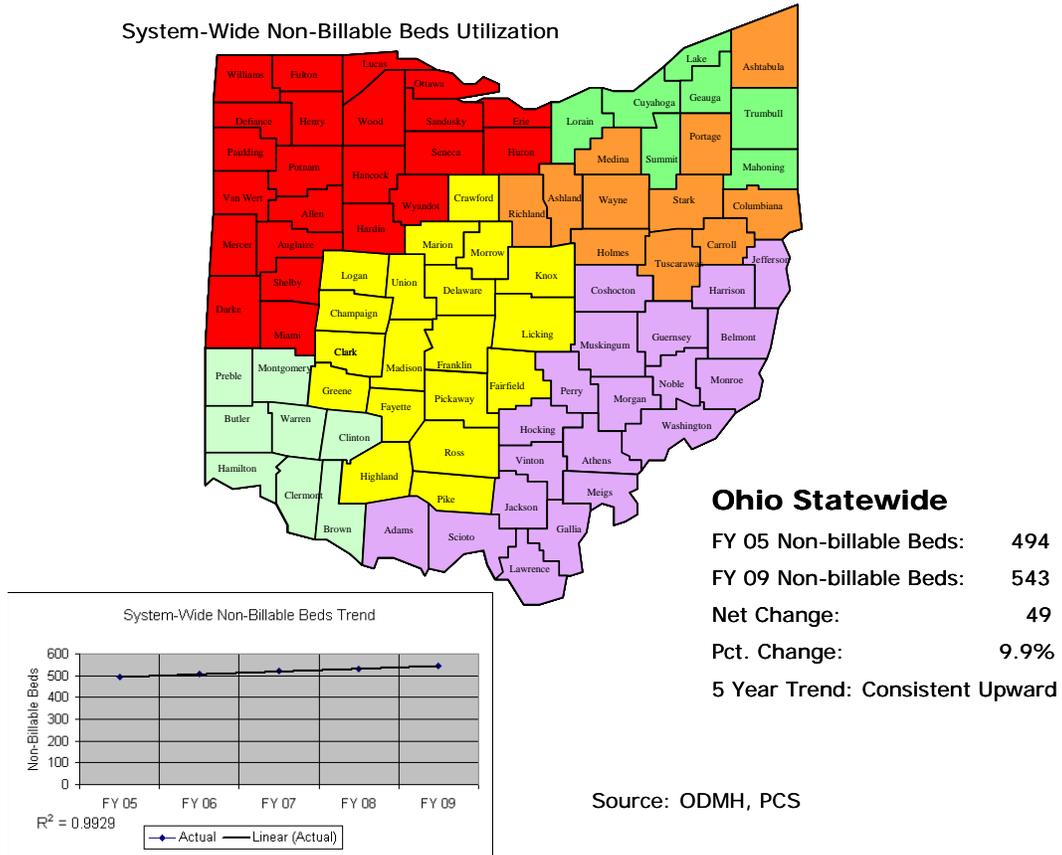


Source: ODMH, Patient Care System

Note: Actual data line and linear trend line are essentially identical.

Translating the non-billable forensic beds days into actual beds, we find a net increase of 49 beds used throughout the system, an increase of nearly 10 percent since FY 2005. See Figure No. 47.

Figure No. 47.



Regional Differences in Non-Billable Bed Days

As with billable bed days, there are differences among the regions in terms of the trend for non-billable bed days. While non-billable bed days are not the financial responsibility of the local ADAMH Boards, they do consume a larger share of available beds, which directly impacts on overall bed availability. Note: the bed days are based on the board's aggregate number of bed days used and not on the state hospital in the region.

Southeast Region

The Southeast Region has experienced a steady increase in the non-billable bed days and thus beds needed over the past five years. The 41 percent increase in non-billable beds in just five years represents an annual increase of more than eight percent. See Figure No. 48.

Figure No. 48.

Southeast Region Utilization

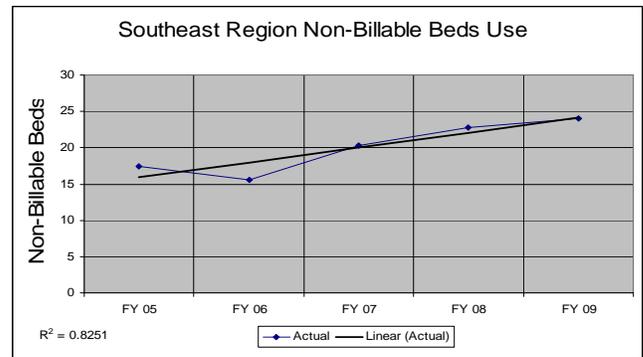
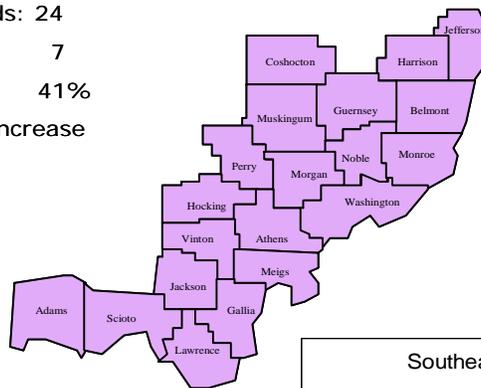
FY 05 Non-billable Beds: 17

FY 09 Non-billable Beds: 24

Net Change: 7

Pct. Change: 41%

5 Year Trend: Sharp Increase



Southwest Region

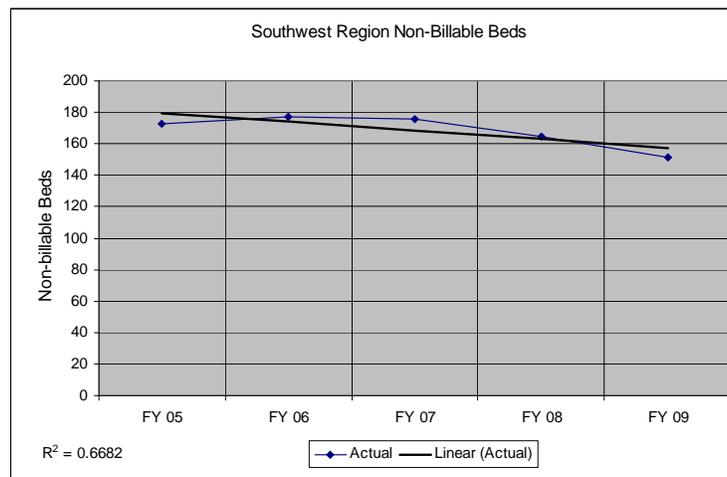
The Southwest Region has experienced an overall decline in non-billable bed days and thus non-billable beds used over the past five years. See Figure No. 49. A primary driver in this reduction is the shift from inpatient competency restoration to out-patient restoration in some cases. For example, in FY 2008, there were 323 misdemeanor cases treated at Summit Behavioral Healthcare. In FY 2009, the number of cases declined by 90 to 233 cases; or 28 percent⁷⁶ During the same period of time, the number of misdemeanor opinions declined in the Municipal courts within the Southwest region. In FY 2008, there were 190 opinions, and in FY 2009, there were 123 opinions; a decline of 35 percent.⁷⁷

Figure No. 49.



Southwest Region Utilization

FY 05 Non-billable Beds:	173
FY 09 Non-billable Beds:	151
Net Change:	-22
Pct. Change:	-12.7%
5 Year Trend:	Inconsistent but Slight Downward



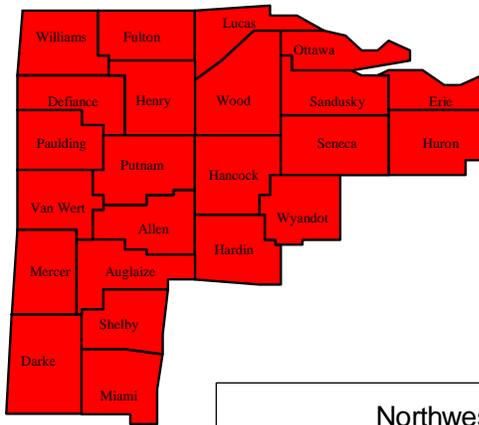
⁷⁶ ODMH, Patient Care System, "Misdemeanor Trends by Hospital, Last 16 Quarters from FY 06 (3rd Quarter) to FY 10 (2nd Quarter), March, 2010.

⁷⁷ ODMH, Forensic Services, "Community Forensic Psychiatry Centers Database, March, 2010.

Northwest Region

The Northwest Region has remained essentially flat in terms of non-billable bed days used-- a range of between 57 and 59 non-billable beds. See Figure No. 50.

Figure No. 50.



Northwest Region Utilization

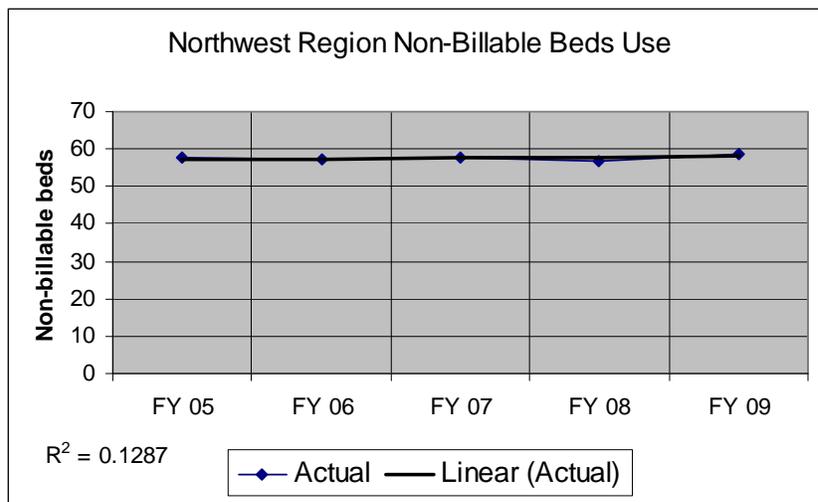
FY 05 Non-Billable Beds: 58

FY 09 Non-Billable Beds: 59

Net Change: 1

Pct. Change: 1.7%

5 Year Trend: Flat



Northeast Region

The Northeast Region has experienced a steady increase in non-billable bed days and thus non-billable beds needed over the past five years. See Figure No. 51. The increase in non-billable bed days by nearly 26 percent equates to an annual increase of more than five percent.

Figure No. 51.

Northeast Region Utilization

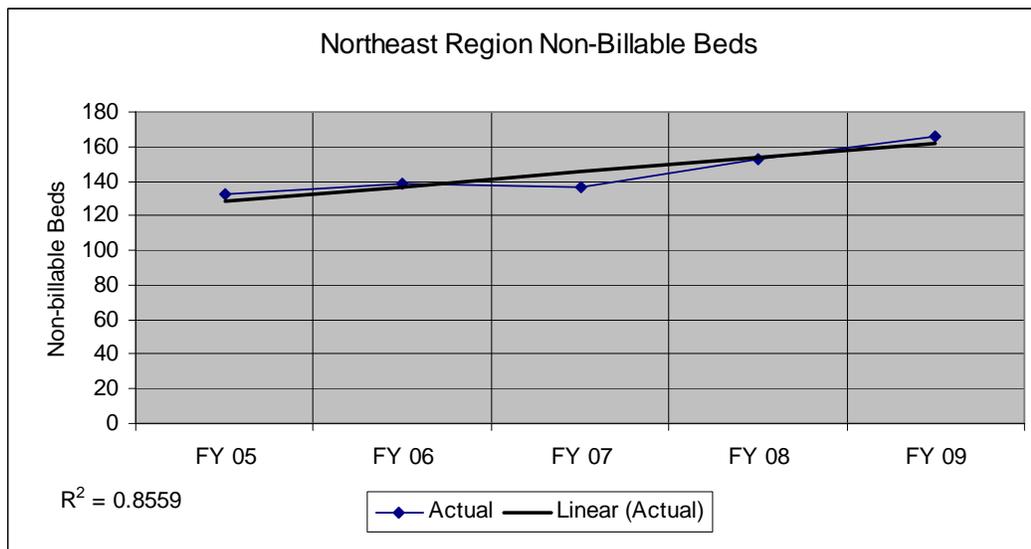
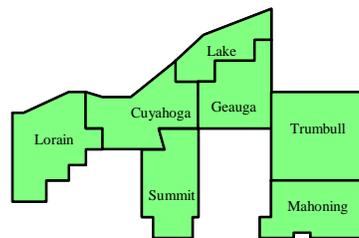
FY 05 Non-billable Beds: 132

FY 09 Non-billable Beds: 166

Net Change: 34

Pct. Change: 25.7%

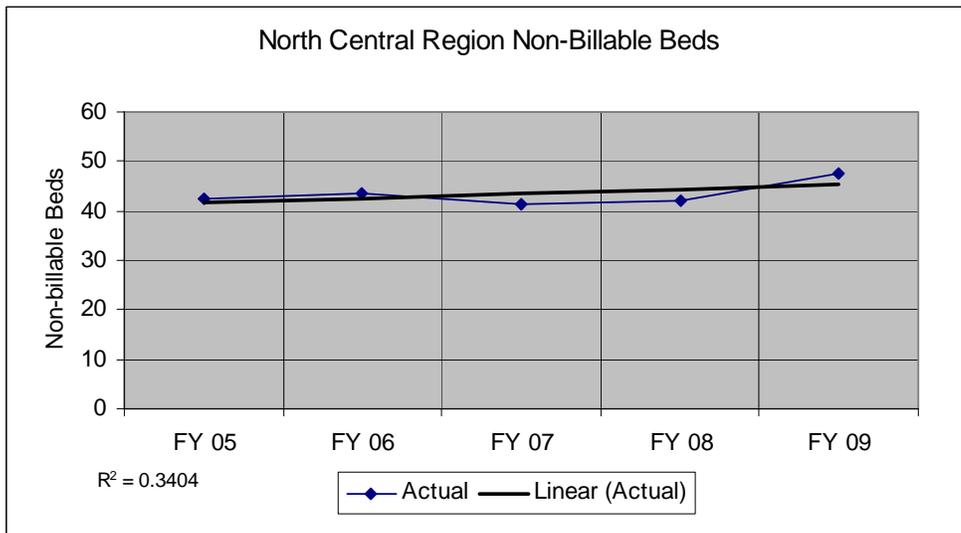
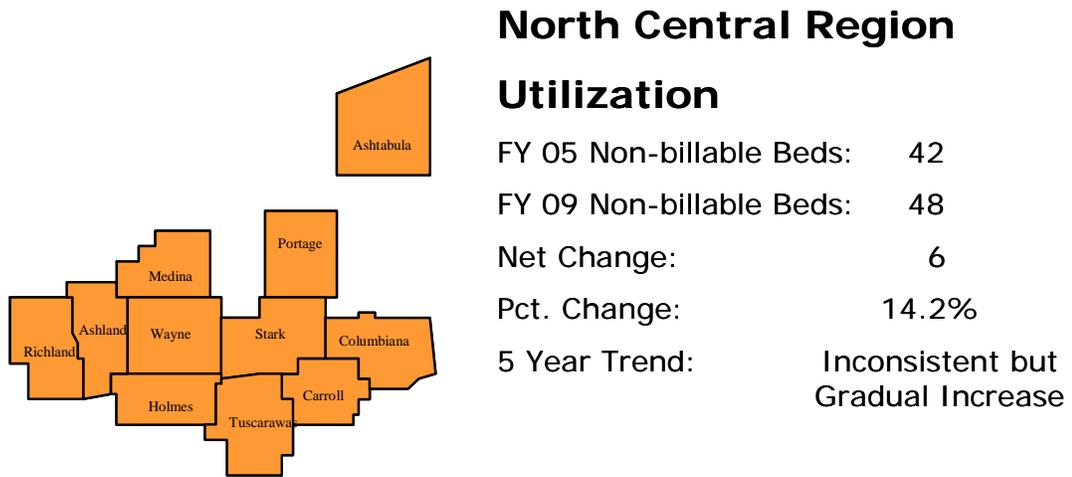
5 Year Trend: Consistent and
Gradual Increase



North Central Region

The North Central Region has experienced an inconsistent but overall increase trend in non-billable bed days and thus non-billable beds needed over the past five years. See Figure No. 52.

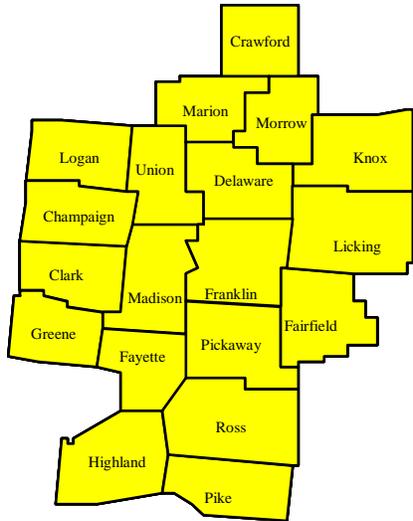
Figure No. 52.



Central Region

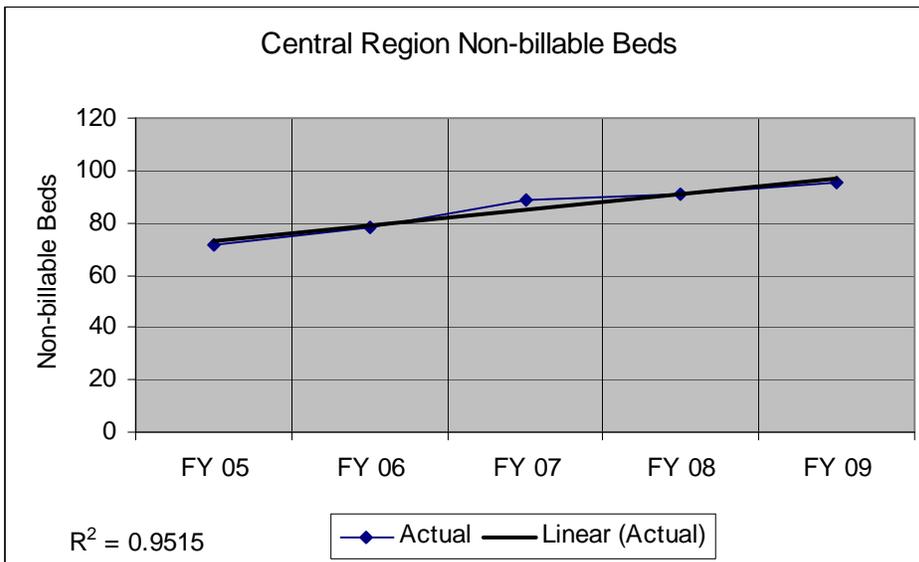
The Central Region has experienced a steady increase in non-billable bed days and thus non-billable beds needed over the past five years. See Figure No. 53. The increase in non-billable bed days by nearly 34 percent equates to an annual increase of just below seven percent.

Figure No. 53



Central Region Utilization

FY 05 Non-billable Beds:	71
FY 09 Non-billable Beds:	95
Net Change:	+24
Pct. Change:	33.8%
5 Year Trend:	Consistent Increase



Part III Forensic Inpatient Psychiatric Services Key Points

- 1) The forensic status patients' bed days continue to increase though at a rate much lower than the rate of the civil bed days decline. Overall, during the past couple of years, the forensic status bed day use has started to level off slightly.
- 2) Currently, the forensic status patients' bed days comprise two-thirds of all the state hospital bed days. It is forecasted that civil bed days use will continue to decline and forensic bed day use will continue to increase, leading to a continuing (albeit gradual) increase in the percentage of the total bed days consumed by forensic status clients.
- 3) The non-billable forensic bed day use has accounted for the increase in the overall forensic status bed day use. The non-billable forensic statuses are more likely to have longer average lengths of stay, resulting in increased bed day use.
- 4) Competency-to-stand-trial admissions have shown a marked increase over the past decade and comprise the largest percentage of forensic non-billable bed days. During the corresponding period of time, the number of Not Guilty by Reason of Insanity (NGRI) bed days has declined.
- 5) The Not Guilty by Reason of Insanity legal status has shown an increase in the past three years, although compared to 10 years ago the actual number is slightly lower. The NGRI legal status comprises one of the longest lengths of stays.
- 6) Not Guilty by Reason of Insanity patients may achieve a stabilization of symptoms and a reduction of risk management behaviors that would enable them to be treated in a lesser restrictive treatment environment than the state hospital. However, the absence of secure and safe community alternatives results in the Not Guilty by Reason of Insanity patients continuing to occupy an acute care hospital bed.
- 7) Across regions there are marked differences in the trend of non-billable bed days use. The Central and Northeast regions are experiencing the most marked increases in non-billable bed day use. The Southeast Region is also experiencing an increased use of non-billable bed days. The Northwest and North Central Regions are also experiencing modest increases in non-billable bed day use.

Only the Southwest region has experienced a decline in non-billable bed day use. The decline in the region can be attributed to the greater use of outpatient competency treatment for competency restoration of misdemeanor crimes, in lieu of inpatient hospitalization.

Part IV

Mental Health Funding

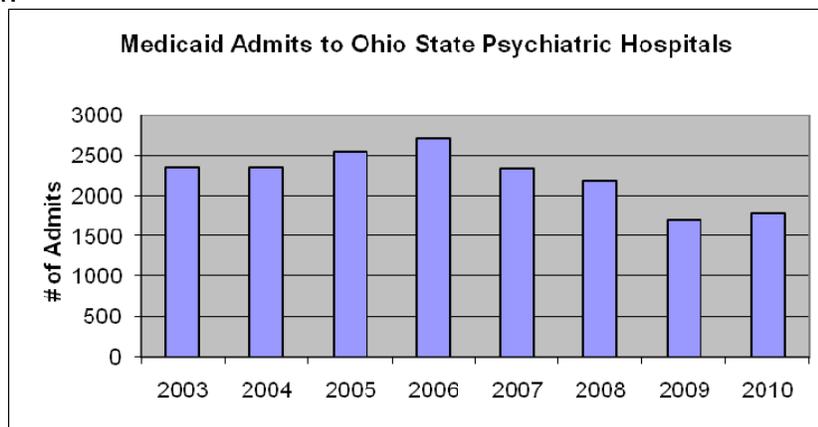
Part IV

Mental Health Funding

Payer Mix in the State Hospitals

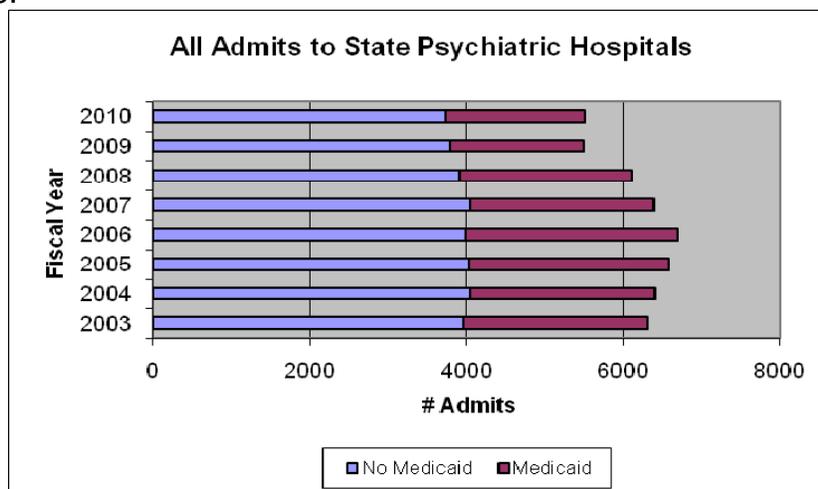
Patients with Medicaid coverage at the time of admission have consistently comprised between 37 percent and 40 percent of all admissions to state hospitals. Note: Patients with Medicaid coverage include those individuals who may have been enrolled in a Medicaid managed-care plan as well. See Figure No. 54. While admissions overall have declined, the percentage with Medicaid coverage remained consistent. See Figure No. 55. This raises the question of whether or not state hospitals are to be the 'safety net of services' for those who are indigent.

Figure No. 54.



Source: ODMH, Office of Medicaid

Figure No. 55.



Note: Percentage is the percentage of Medicaid admits of all admits

Source: ODMH, Office of Medicaid

The 2004 Report warned of a foreboding change that was under consideration by the Centers for Medicare and Medicaid Services that would create the Prospective Payment System (PPS). The proposed change would “*decrease the reimbursement for non-governmental psychiatric facilities and could result in the closures of psychiatric units and hospitals.*”⁷⁸ The proposed rule change was made effective January 1, 2005.⁷⁹

The new rule replaced the reasonable cost based reimbursement with a per diem prospective payment system for Medicare. The new rule change was phased in over a period of three years. During the transition period, payment was calculated based on blending the federal per diem payment amount and a facility or hospital specific payment rate, with the federal per diem rate being the greater part of the blended rate.

⁸⁰ By July 1, 2008, the PPS payment was entirely based on the federal per diem payment amount. ⁸¹ The change was predicted to result in a 16.33 percent reduction in the payments that hospitals would receive compared to the cost-based payments. ⁸²

The 2004 Report noted that a 2001 ODMH survey of recently closed general hospital psychiatric units, found that 36 percent cited fiscal pressures, 23 percent noted reorganization and mergers, and nine per cent indicated they just discontinued offering psychiatric services. The survey concluded, “...68 percent of those psychiatric units that closed indicated that funding and related reorganization issues were the primary reason for closure.” ⁸³ The decrease in funding as a result of the Medicare PPS rule change is a likely cause of continued closures and decisions by private hospital administrators who need to reconsider the inpatient psychiatric services in their hospital’s array of programs.

CURRENT MENTAL HEALTH FUNDING

The 2004 Report indicated that “the rapidly evolving fiscal environment has transformed the way that inpatient and emergency psychiatric care, both public and private, is being managed and delivered. These changes are being experienced within the mental health system, as well as externally, from health care in general.” The 2004 Report went on to query, “What are some of the financial changes that have molded this picture in states that are uniformly experiencing this crisis in acute mental health care?”⁸⁴ The report identified the following financial issues:

“• Reduced mental health budgets forcing the closing of state hospitals and decreasing the capacity of community mental health systems;

⁷⁸ National Association of State Mental Health Program Directors, letter, February, 2004.

⁷⁹ Deloitte & Touche LLP, “CMS Issues Final Inpatient Psychiatric PPS Rule; Effective Beginning January 1, 2005” in *Washington Commentary: A Perspective of Legislation and Regulation, November 7, 2004, p. 2.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 12.

⁸⁴ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 11.

- Cost-cutting practices implemented by managed care organizations;
- Inefficiencies and poor coordination among and between payers and providers;
- Lack of parity with physical medicine; and
- Increasing public awareness and demand for services.”⁸⁵

In 2010, the same financial issues appear to remain. The economic recession that has afflicted the economies of many of the industrialized nations across the world has been keenly felt in the United States. Midwest states like Ohio have been severely affected. The downturn in the economy has had a direct and dire impact on state revenues especially from personal and corporate taxes. Between FY 2008 and FY 2010, Governor Ted Strickland called for significant budget reductions which have impacted directly on the delivery of mental health services in the state. Tough choices had to be made and the cuts were shared by the state’s hospital system and local community programs.

ODMH Director Sandra Stephenson decided to address the initial mandated budget reductions totaling \$31 million through the consolidation of four psychiatric sites into two psychiatric hospitals and a 20 percent decrease in central office administrative expenditures. The hospitals identified were Cambridge Campus of the Appalachian Behavioral Healthcare and the Dayton Campus of Twin Valley Behavioral Healthcare. A major stipulation of the closing of the two campuses was not to reduce the number of inpatient beds operated by the Department. Inpatient beds were added at the remaining facilities to offset the loss of beds created by the campus closures.

Subsequent budget reduction mandates required additional trimming of the ODMH general revenue fund. Having already closed two state hospital campuses, the state could ill afford further state hospital closures at this time. Accordingly, the Director decided that reductions would be shared by the local community system of care and by the Department. Appropriations to the community were reduced by \$10.2 million in September 2008 and \$29 million in January 2009.

The percentage of budgets for state psychiatric hospitals programs operated by State Mental Health Authorities (SMHA) nationally has also declined to “now make up less than 50 percent of total mental health expenditures, as most new money available in the last 20 years has been allocated to community programs.”⁸⁶ The focus group noted that “per capita SMHA-controlled revenue allocated to state hospitals is \$28.92, compared to a per capital SMHA-controlled revenue allocation to community programs of \$61.47 (NASMPD Research Institute, 2003).”⁸⁷ For the most part, the ‘new money’ referenced was Medicaid dollars. The focus group concluded, “The impact on acute psychiatric inpatient care has been predictable.”⁸⁸ The impacts cited by the focus group included:

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ Ibid.

- “Aggressive management of lengths of stay is primarily a cost-containment strategy that, in the context of acute psychiatric care, is more about managing bed utilization than about managing treatment.”⁸⁹
- The shorter lengths of stay in psychiatric hospitals are “an adaptation to a reimbursement system that restricts care and hastens discharge, leading to poor quality care.”⁹⁰
- In the absence of a consensus on a clinical standard to determine appropriate length of stay, the default is “discharge decisions [that] are driven by pressure to manage bed utilization and costs.”⁹¹
- In addition to persons being discharged “before clinically appropriate, fiscal restraints result in referrals “for acute care to service entities that may be geographically inaccessible to them, or not admitted to service at all.” The result is “community mental health programs spend excessive amounts of time and expense trying to locate inpatient space at distant facilities, resulting in expensive ambulance transports.”⁹²
- “The impact of delivering uncompensated hospital care to uninsured individuals has fallen disproportionately on private, free-standing psychiatric hospitals, since Disproportionate Share Hospital Program (DSH) payments are primarily allocated to state public psychiatric hospitals.”⁹³ **This situation holds true for most states, but not Ohio.** While Ohio uses state hospital care costs to provide the state match for DSH funding, Ohio distributes DSH payments to private and free-standing psychiatric hospitals, as well as to the Ohio Department of Jobs and Family Services for defined purposes.
- Due to limited health insurance or no insurance at all, many people in a psychiatric crisis have limited clinical options that “increases clinical and financial pressures on public and private hospitals.”⁹⁴
- A reduction in available psychiatric beds in medical/surgical care general hospitals as hospital administrators are deciding to shift those beds “licensed for psychiatric care to beds licensed for more lucrative medical/surgical care.”⁹⁵
- “Resource limitations prevent recruitment and retention of appropriately trained mental health professionals, particularly in less urban areas.”⁹⁶

How are the Mental Health Funds Spent?

As equally important as knowing where the mental health money is coming from, is to understand how the money is being spent. A dramatic shift in the how the mental health dollars are spent is taking place. Just 22 years ago, the largest expenditure by far went to hospital care (41 percent) with nursing homes a distant second (14 percent).

⁸⁹ Ibid.

⁹⁰ Ibid.

⁹¹ Ibid.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Ibid.

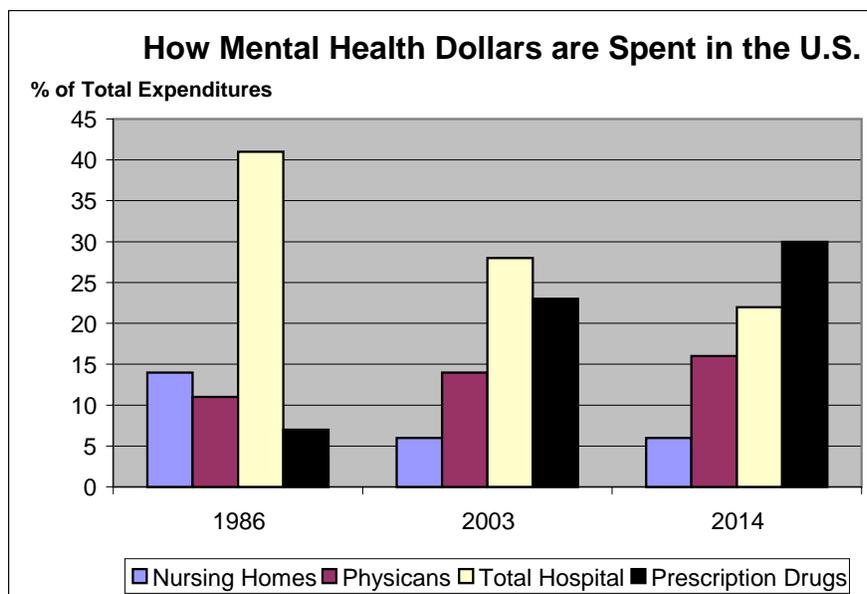
⁹⁵ Ibid., p. 9.

⁹⁶ Ibid.

Prescription drugs ranked next to last in spending at just seven percent. However, by 2003, total hospital care still led in terms of percentage at 28 percent, but just barely over prescription drug costs which now had increased to 23 percent of total expenditures. Nursing Home costs had dropped to just six percent. The forecast is that by 2014, prescription drugs will replace total hospital care as the primary mental health cost accounting for 30 percent of the total mental health expenditures. Total hospital care is forecasted to continue to decline to only account for 22 percent of the expenditures, while nursing home care is predicted to level off at six percent. ⁹⁷

Physician costs are forecasted to also increase and will make up the third highest category of mental health expenditures at 16 percent. Other professionals' costs will remain at half that percentage (8 percent), while multi-service mental health organizations and insurance administration will account for the remaining expenditures (10 and 6 percent respectively). ⁹⁸ See Figure No. 56.

Figure No. 56.



Source: Katharine R. Levit, et.al. *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014*, 2008.
 Note: Remaining Expenditures in order of their 2014 projection are:
 Multi-service Mental Health Organizations (10%), Other Professionals (8%),
 and Insurance Administration (6%).

The growth in the spending on prescription drugs is expected to average around 9.2 percent annually through 2014. This annual growth actually represents a slowing down

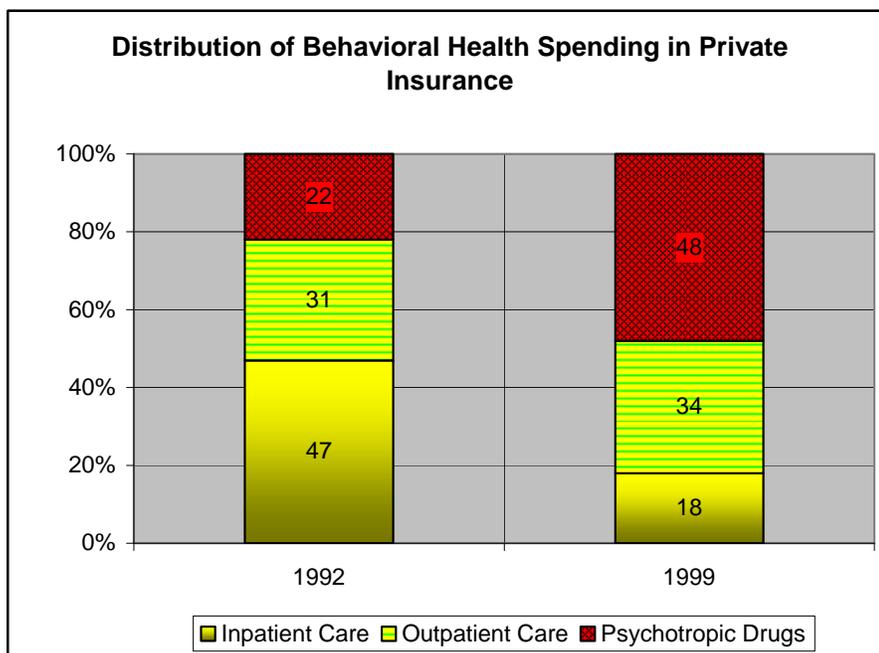
⁹⁷ Katharine R. Levit, et.al., *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014*, 2008, p. 22.

⁹⁸ *Ibid.*

of growth compared to the period from 1986 to 2003. The National Association of Psychiatric Health Systems observed that the distribution of behavioral health spending by private insurance on psychotropic meds increased from 22 percent in 1992 to 48 percent in 1999, more than doubling of the drug costs in just seven years. At the same time, inpatient costs declined from 47 percent to just 18 percent during the same seven year time period. Outpatient costs remained essentially the same only increasing by three percent to represent 34 percent of the total distribution of behavioral health spending by private insurance.⁹⁹ See Figure No. 57.

Figure No. 57.

Distribution of Behavioral Health Spending in Private Insurance



Source: NAPHS, National Trends: Challenges Facing Behavioral Health Care, April, 2003, p. 2.

The driver of the increased costs of the prescription drugs were the second generation antipsychotic or atypical medications that were introduced into the market beginning in the mid-1990s. The pharmaceutical companies' own research held out the promise that the second generation antipsychotic medications could improve negative symptoms while at the same time having reduced incidences of side effects. A major marketing campaign by the pharmaceutical companies was a success. By the beginning of the

⁹⁹ National Association of Psychiatric Health Systems, *National Trends: Challenges Facing Behavioral Health Care: the Pressures on Essential Behavioral Healthcare Services*, April, 2003, p.2.

21st century, the second generation antipsychotic medications commanded 90 percent of the U.S. market.¹⁰⁰

For a few years the promise of significant improvement in the patient's clinical condition seemed to have been fulfilled. The marked increase in costs for the second generation psychotropic medications seemed to have been money well spent. Then, serious medical problems began to be associated with some of the second generation antipsychotic medications. The serious medical conditions included agranulocytosis (a decrease in white blood cells) that was associated with Clozaril and required close monitoring with at least weekly blood analysis. Also, olanzapine (Zyprexa) was associated with marked weight gain and altered glucose and lipid metabolism.¹⁰¹ Finally, an independent objective study was funded by NIMH. After four years of study, the findings were published in 2005 and noted that most of the second generation antipsychotic medications did not perform better when compared against Trilafon, a first generation antipsychotic medication. The one second generation drug that did seem to have a better clinical response, though not markedly so, was Zyprexa. However, by then, Zyprexa was associated with the significant weight gain and other metabolic changes that increased the risk for Diabetes Mellitus or cardiovascular problems. The study concluded "How clinicians, patients, families and policymakers evaluate the trade-offs between efficacy and side effects, as well as drug prices, will determine future patterns of use"¹⁰² for the second generation antipsychotic medications.

The managed care companies and consumers reacted to the high cost of the second generation antipsychotic medications by increasingly requesting the first generation antipsychotic medications that were now off-label and available as a lower cost generic medication. Thus the primary reason for a slower increase in the prescription drug costs were due to "restructuring of drug insurance benefits that encourages consumers to purchase lower cost generic drugs rather than branded products that require higher cost-sharing."¹⁰³ Despite this slower growth, prescription drug costs are still predicted to account for 30 cents out of every one dollar of spending. This trend is likely to continue as "the development and use of MH [mental health] drugs with fewer side effects have heightened primary care physicians' comfort with and involvement in prescribing MH drugs, leading to a growing share of MH [mental health] prescriptions being ordered by primary care physicians."¹⁰⁴ Whether the consumers' movement towards preferring generic drugs and "redesigned insurance plans aimed at reducing costs through the use of drug formularies"¹⁰⁵ will offset the overall increase in prescriptions and the cost of psychotropic medications remains to be seen. For now, it appears these interventions

¹⁰⁰ Jeffrey Lieberman, et.al. "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia," in *The New England Journal of Medicine*, Vol. 353:1209-1223, September 22, 2005, Number 12.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Katharine R. Levit, et.al., *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014*, 2008, p. 23.

¹⁰⁴ Ibid., p. 26.

¹⁰⁵ Ibid.

will slow but not alter the overall trend to an increasing percentage of mental health costs being spent on prescription drugs.

SMHA-Controlled Expenditures

The National Association of State Mental Health Program Directors (NASMHPD) conducted a study in September 2007 that examined the State Mental Health Authorities (SMHA) expenditures. One of the key findings was that nationally, while the constant dollars controlled by the SMHA have continued to steadily increase (from \$16.8 billion in 1997 to \$29.4 billion in 2005), when adjusted for inflation, the increase is more modest; only \$1.6 billion (from \$5.9 billion in 1997 to \$7.5 billion in 2005).¹⁰⁶ Another way to look at the same data is on a per capita basis. Inflation adjusted, the increase represents an increase of only \$4 per person from 1997 to 2005.¹⁰⁷

In a comparison of the states' percentage of total state government expenditures that were controlled by the SMHA, in FY 2005 the Ohio Department of Mental Health controlled 1.5 percent of the total state government expenditures. This percentage ranked Ohio 38th out of the 50 states. The national average was 2.4 percent. Pennsylvania had the highest percentage of expenditures controlled by the SMHA at five percent. Michigan, similar in population to Pennsylvania and Ohio, came in at the national average of 2.4 percent. The lowest percentage was New Mexico at 0.4 percent.¹⁰⁸

On a national basis, the average annual change in major state government expenditures from FY 2001 to FY 2005 was 4.6 percent. The total SMHA-controlled expenditures increased by 6.3 percent, which was higher than the overall increase in state government and nearly all other state government programs including education, public assistance, corrections and transportation. The increase in the SMHA-controlled expenditures was lower than Medicaid costs, which rose nearly nine percent (8.9 percent).¹⁰⁹ Within the SMHA-controlled expenditures, community mental health funding increased by 8.3 percent while state psychiatric inpatient hospital spending increased only three percent.¹¹⁰

On a national basis, in terms of the primary revenue sources controlled by the SMHA in 2005, the state General Revenue Funds (GRF) were the highest percentage (40 percent), followed by Federal Medicaid (26 percent), State Medicaid Match (16 percent), and other state funds (seven percent). The remaining 11 percent was comprised of Medicare, Mental Health Block Grant, other federal, other local, and other sources of revenue not identified.¹¹¹

¹⁰⁶ Ted Lutterman, *Fiscal Year 2005 State Mental Health Agency Revenues and Expenditures: Key Findings*, NASMHPD Research Institute, September, 2007.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ Ibid.

¹¹¹ Ibid.

The NASMHPD study found that nationally, Medicaid had the highest percentage increase in SMHA-controlled revenue for the time period FY 2001 to FY 2005. Medicaid increased by 46.4 percent during this time period. At the same time, state GRF increased by only 15.2 percent. The two primary sources of revenue have been sharply converging toward one another in terms of total SMHA-controlled revenue since 1990. In 2005, state GRF comprised 47 percent of the total revenue funds, and Mental Health Medicaid (federal and state match) comprised 42 percent.¹¹² Although the decline in state GRF has leveled off over the past four years, as has the increase in Mental Health Medicaid, the continuing trend would indicate a potential switching in the ranked percentages of the two major sources of SMHA funding in the next few years. All other sources of funding have remained relatively stable fluctuating between 11 and 12 percent.¹¹³

Nationally, in terms of the SMHA-controlled revenues to pay for the state inpatient psychiatric hospitals, state GRF were the highest percentage (61 percent), followed by Federal Medicaid (16 percent) and State Medicaid Match (10 percent). In terms of community mental health, the SMHA-controlled revenue make up was quite different; Federal Medicaid comprised the largest percentage (31 percent), followed by state GRF (30 percent), and state Medicaid match (20 percent). Local funding comprised just 1.6 percent of the total community mental health revenue controlled by the SMHA.¹¹⁴

The study compared the SMHA-controlled Medicaid revenues as a share of the total state Medicaid. Ohio came in 31st out of the 50 states and District of Columbia, with the state SMHA controlling 2.6 percent of the total state Medicaid. Arizona had the highest percentage at 14.9 percent, and New Mexico the lowest at 0.2 percent. The median was 3.6 percent. Michigan ranked 13th in the comparison study with 6.9 percent of the state Medicaid controlled by the SMHA; Pennsylvania ranked 20th with 4.3 percent of the funding.¹¹⁵

Nationally, since 1981, the two primary expenditures for SMHA have been community mental health and state inpatient hospitals. In 1981, the state inpatient hospitals comprised 63 percent of the expenditures, and the community mental health, 33 percent. For the next 12 years, the two expenditures gradually came closer to one another as state mental hospital expenditures gradually decreased while community mental health funding increased. In 1993, the two major expenditures were essentially the same (state mental hospitals at 48 percent and community mental health at 47 percent). Since 1994, community mental health has continued to climb as state mental hospital expenditures continued to decline by nearly the same rate. In 2005, community mental health comprised 70 percent of the SMHA-controlled expenditures and state mental hospital care comprised just 27 percent. The result is greater than a complete reversal in terms of the percentage the two major expenditures held 24 years ago.¹¹⁶

¹¹² Ibid.

¹¹³ Ibid.

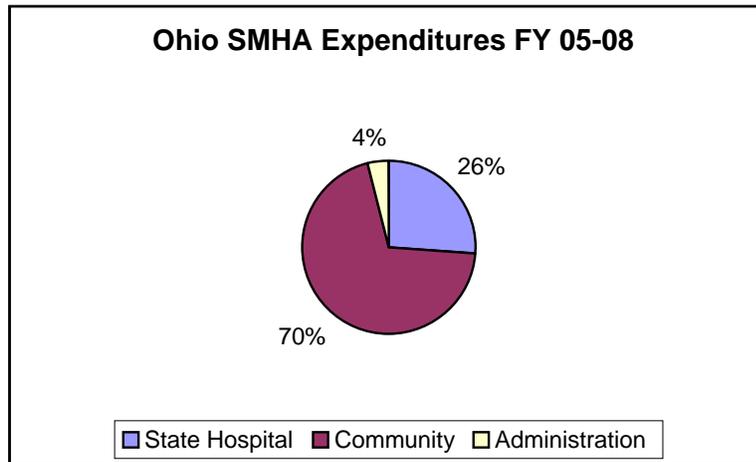
¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

In Ohio, the experience was very similar to the national trend. The Ohio Department of Mental Health expenditures for fiscal years 2005 to 2008 were 26 percent for state hospital operations, 70 percent for community services, and the remaining four percent was spent on administration. See Figure No. 58.

Figure No. 58.

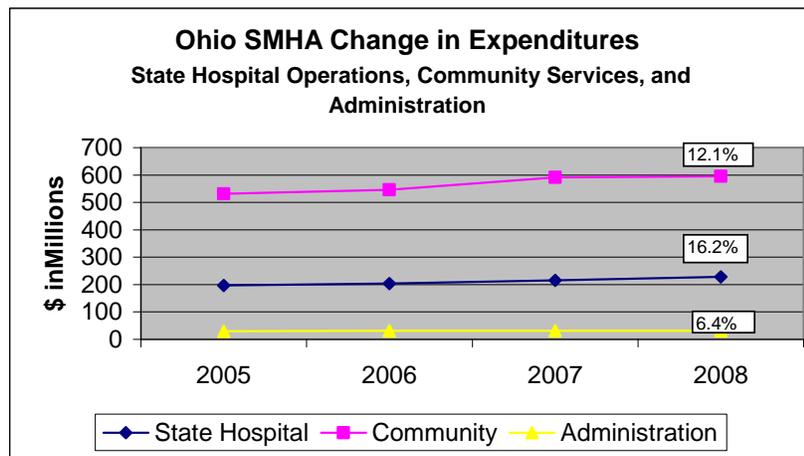


Source: ODMH, Fiscal Services

The Ohio SMHA distribution in the three main expenditure categories remained fairly constant during fiscal years 2005 to 2008. During this time period, state hospital operations increased by 16.2 percent, community services by 12.1 percent and administration by 6.4 percent. See Figure No. 59.

Figure No. 59.

Ohio SMHA Expenditures for State Hospital Operations and Community Services



Source: ODMH, Fiscal Services

Medicaid Disproportionate Share (DSH) Payments

As noted above, the Centers for Medicare and Medicaid Services provides Medicaid Disproportionate Share (DSH) payments to psychiatric hospitals. The DSH payments were established by the U.S. Congress in the early 1980s “to provide some financial relief to hospitals serving the poor.”¹¹⁷ thereby enabling the hospitals to continue to operate and provide continued access to quality services for the poor. To that end, DSH is designed to reimburse medical/surgical and psychiatric hospitals for uncompensated costs for services provided to low income and Medicaid patients. Further, Medicaid requires the states to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs when setting inpatient hospital rates.”¹¹⁸

Ohio’s DSH program in Federal Fiscal Year (FFY) 2007 amounted to \$641.3 million dollars, of which \$93.4 million was carved out for the Psychiatric DSH program. Ohio, like all states, is required to provide the state match based on its federal financial participation (FFP) ratio. Regarding Ohio’s psychiatric DSH program which amounted to \$93.4 million in FFY 2007, the state hospitals provided for \$143.8 million in uncompensated care, of which \$36.7 million was used for the state match for the DSH payment requirement. The FFP to Ohio’s psychiatric DSH program was \$55.7 million in FFY 2007. ODMH received approximately \$2.3 million in DSH payments which were distributed among three private psychiatric hospitals.¹¹⁹ The remaining balance of the psychiatric DSH funding (approximately \$91.1 million) is under the control of the Ohio Department of Job and Family Services.

Overall Mental Health Funding Comparison

The discrepancy in mental health funding exists in areas beyond DSH payments. When comparing Ohio to Michigan and Pennsylvania in terms of other funding sources, Ohio continues to lag behind despite similar-sized populations. Ohio receives 54 percent of its mental health revenues from the state GRF, compared to Michigan at 34 percent, and Pennsylvania at 64 percent. However, in terms of total Medicaid payments, in FY 2005 Ohio received \$329 million that accounted for 41 percent of total mental health revenue; an increase of two percent from 2004. For the same year, Michigan received \$600.9 million in Medicaid payments that accounted for 62 percent of its total mental health funding; an increase of three percent from 2004. Pennsylvania received \$710.1 million in Medicaid payments that accounted for just 28 percent of its total mental health budget; down one percent from 2004.¹²⁰

¹¹⁷ Teresa A. Coughlin, et al., “Reforming the Medicaid Disproportionate Share Program”, *Health Care Financing Review*, Vol. 22, No. 2, Winter, 2000, p. 138.

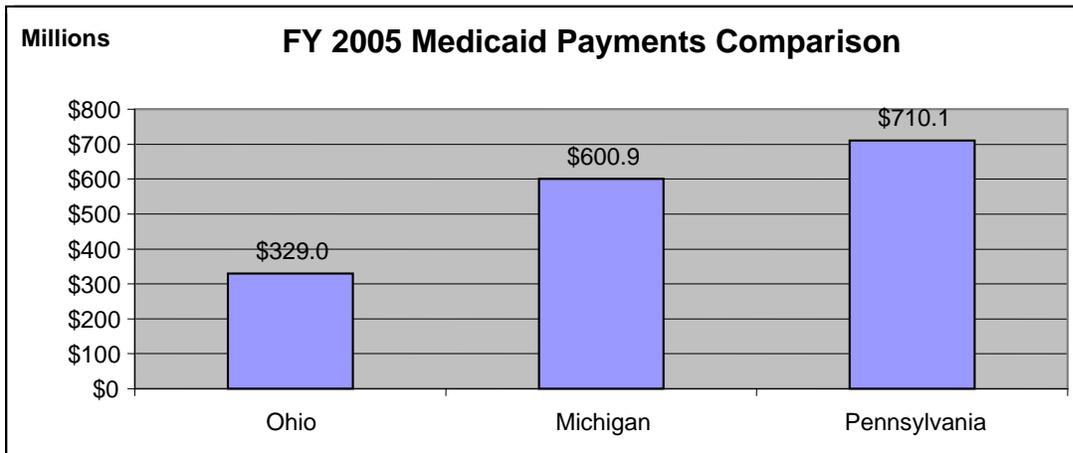
¹¹⁸ *Ibid.*, p. 138.

¹¹⁹ ODMH, Fiscal Services, Ohio Medicaid DSH Payments, FFY 2007. Numbers are rounded.

¹²⁰ NASMHPD Research Institute, *Revenue and Expenditures Reports from 2005*, Table 23: State Civilian Population, FY 2005, Mental Health Revenue, By Revenue Source and By State, Table 24.

The graph below depicts the striking comparison between the three states. See Figure No. 60.

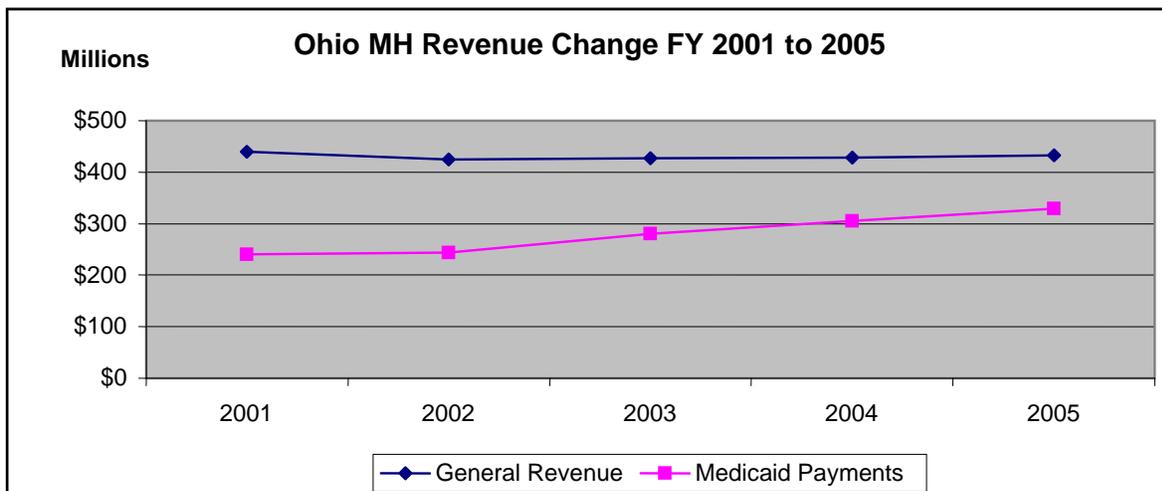
Figure No. 60.



Source: NRI FY 2005, Table 24, SMHA-Controlled Mental Health Revenues, By Revenue Source and by State

In terms of the change over time in Ohio's mental health funding, the trend is for a gradual reduction in GRF and at the same time a gradual increase in Medicaid funding. In FY 2005, the mental health funding was 54 percent from the GRF and 41 percent from Medicaid. See Figure No. 61.

Figure No. 61.



Source: NRI Reports Table No. 33a: 2001 to 2003; Table No. 24: 2004 and 2005.

Private Hospitals' Discharge by Payer Source

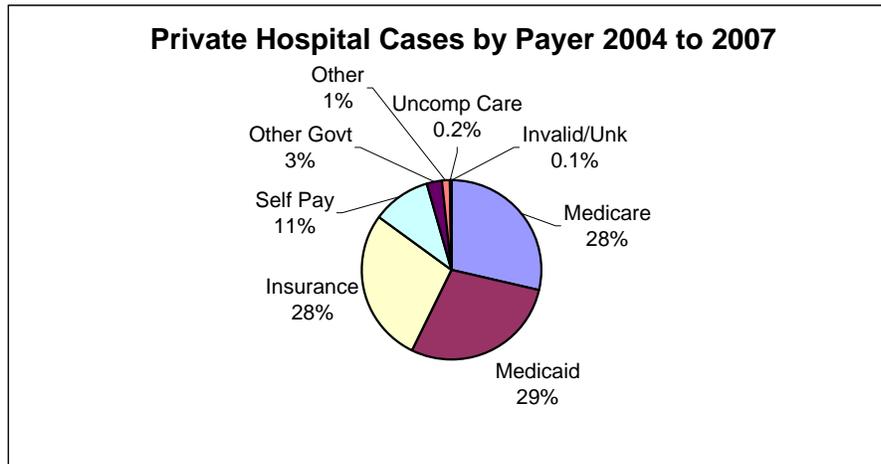
From 2004 to 2007, the make up of discharges from private psychiatric hospitals in Ohio indicates that Medicaid and Medicare combined comprise 57 percent of all discharges. Medicare accounts for the highest percentage of discharges (29 percent), followed by Medicaid (28 percent), private insurance (27 percent), and self pay (10 percent). The following categories were collapsed into the eight main payer sources:

- Medicare payer source comprised of: Medicare and Medicare Health Maintenance Organization (HMO).
- Medicaid payer source comprised of: Medicaid and Medicaid HMO.
- Insurance payer source comprised of: commercial insurance, HMO, Blue Cross Primary, Preferred Provider Organizations (PPO), Blue Cross HMO, Ohio Hospital Care Assurance Program (HCAP), and Blue Cross Crossover.
- Self-Pay payer source included only self pay.
- Other Government payer source included: Other Government, Workers Compensation and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
- Other payer source included only other category.
- Uncompensated care payer source included: charity uncompensated and bad debt uncompensated care.
- Invalid/Unknown payer source included only the invalid/unknown category.

Source: Ohio Hospital Association, MI by Payer Spreadsheet, 8/25/2008.

The information includes Medicare and Medicaid clients who are now enrolled in a managed care program as well. See Figure No. 62. As with community Medicaid, the federal programs are the significant payer for inpatient psychiatric services. An examination of the uncompensated and charity care reveals that the private psychiatric hospitals are providing two-tenths of one percent (0.2%) of the total payer sources for persons who could not or would not pay for their services received. See Figure No. 62 on the following page.

Figure No. 62.



Source: Ohio Hospital Association, 2008

The change over time is fairly consistent and level for the past four years for the payer sources. Table No. 63 displays changes among the top four payer sources during the past four years for private psychiatric hospitals in Ohio based on the percentage and total number of discharges. While the overall trends are flat, there was a distinct increase of seven percent in private insurance discharges from 2006 to 2007, while at the same time Medicaid discharges dropped 14 percent. Whether this change represents a trend or just a one year adjustment will need to be evaluated over time.

Table No. 63.

Private Hospital Discharges Rank Order of top Four Payer Sources from 2004 to 2007

	2004		2005		2006		2007	
	N	Pct	N	Pct	N	Pct	N	Pct
Medicare	27823	28.65%	26792	28.31%	27167	28.45%	26843	29.04%
Medicaid	27877	28.70%	27378	28.93%	27245	28.54%	23359	25.27%
Insurance	26865	27.66%	24086	25.45%	25626	26.84%	27372	29.61%
Self Pay	10231	10.53%	9873	10.43%	9587	10.04%	9318	10.08%

Source: OHA, MI by Payer, 8/25/2008.

Note: N= Number of Discharges; Pct. = Percent of total discharges

Table No. 64 reveals the bottom four payer sources during the past four years for the private psychiatric hospitals in terms of the percentage of total discharges. The most significant change was in the 'other category' while other government, uncompensated or charity care, and invalid/unknown remained essentially flat. From 2006 to 2007, other government cases were down 186 cases, and uncompensated/charity care were down 88 cases.

Table No. 64.

Private Hospital Discharges Rank Order of Bottom Four Payer Sources from 2004 to 2007

	2004		2005		2006		2007	
	N	Pct	N	Pct	N	Pct	N	Pct
Other Govt	2704	2.78%	3196	3.38%	2697	2.82%	2511	2.72%
Other	1332	1.37%	3044	3.22%	2882	3.02%	2724	2.95%
Uncomp Care	192	0.20%	235	0.25%	205	0.21%	117	0.13%
Invalid/Unk	103	0.11%	33	0.03%	69	0.07%	193	0.21%

Source: OHA, MI by Payer, 8/25/2008.

Note: N= Number of Discharges; Pct.= Percent of total discharges

Part IV Mental Health Funding Key Points

1) Despite an overall decline in admissions to the state hospitals, the percentage of admissions with Medicaid or other third party payer coverage has remained consistently between 36 and 40 percent. This percentage, coupled with the percentage of patients admitted with a non-billable forensic legal status, accounted for nearly half of all admissions during 2008.

2) There are a variety of reasons why private hospital administrators may reduce or recertify psychiatric beds or even close psychiatric units. Two of the fiscal reasons relate to a decrease in reimbursement for services. The change by the Centers for Medicare and Medicaid Services from a cost-based payment to the Prospective Payment System (PPS) for Medicare has resulted in a net reduction in reimbursement for services rendered.

3) The recession in the U.S. and Ohio economies is significantly adversely impacting on the mental health funding. Between FY 2008 and FY 2010, the Ohio Department of Mental Health has experienced a cumulative total of \$134 million in General Revenue Fund (GRF) budget reductions, the largest percentage reduction taken by any of the state institutional-serving agencies. These reductions have resulted in major reform in the areas of central office administration, hospital restructuring, and community mental health services. As of January 2010, a budget corrective item increased the 408 (community subsidy) by \$7.35m for each year of the FY 2010-2011 biennium.

Efforts are underway at the national and state level to hopefully curtail the recession. It is too early to evaluate whether the interventions under consideration will bring about the intended relief. To contend with the tight financial situation, the Ohio mental health system will strive to achieve greater collaboration and efficiency while stressing the core services for the most severe and at risk citizens in the state.

4) Medicare and Medicaid patients remain the largest percentage of admissions for the private psychiatric hospitals. Commercial insurance is increasing in percentage of overall admissions. Regardless, private insurance remains only the third highest source of admissions behind the federal programs. At the opposite end of the funding spectrum, uncompensated charity care and uncompensated bad debt remain a minute

percentage of the admissions for the private psychiatric hospitals. If the recession and associated unemployment rates worsen, the likelihood is that commercial insurance will decline in percentage as less covered persons will be available to utilize the health care benefit. The anticipated decline in commercial insurance revenue represents a problem in private hospitals funding. In all likelihood, the private psychiatric hospitals will be increasingly disinclined to accept uncompensated charity care or bad debt cases, resulting in increased pressure on the state hospital system.

5) Prescription drug costs are increasing at just below 10 percent annually. By 2014, prescription drug costs will account for 30 cents out of every dollar spent on mental health services, becoming the primary mental health expenditure in the United States. Managed care formularies and the consumers' preference for generic drugs will offset these increases somewhat, but the general trend will continue.

6) Disproportionate Share (DSH) payments are a key issue impacting on Ohio's mental health funding. Ohio lags significantly behind neighboring and similarly populated states such as Michigan and Pennsylvania. The per capita comparison is striking and raises concerns as to why Ohio would receive so little DSH funds compared to these other two states with similar sized populations. A possible reason may be the state hospital Medicaid that is reported. Ohio ranks next to last among states that report state hospital Medicaid for DSH payment calculation. Ohio's payments are significantly less than Michigan or Pennsylvania.

Part V

Mental Health Workforce

Part V

Mental Health Workforce

Healthcare in general remains a growing field. The Office of Workforce Development at the Ohio Department of Job and Family Services, noted in its *2008 Ohio Healthcare Employment: Labor Market Trends and Challenges Report* that, “the healthcare industry is remarkable in that it appears largely resilient to the economic cycles that affect the rest of Ohio and the United States.”¹²¹ The reason cited for this resiliency is that health care is less linked with economic conditions than with public health, age demographics, and government funding and policy decisions. In Ohio, while total employment has been flat from 2000 to 2006, health care employment continues a nearly linear climb. During the past 30 years, healthcare employment in Ohio has grown by 228 percent from 277,500 to 633,000 Ohioans employed in a healthcare field. The estimate is that one in every 18 Ohioans was employed in health care in 2006.¹²²

The *2008 Ohio Healthcare Employment: Labor Market Trends and Challenges Report* related that “at the national and state levels, health care industries are projected to create more new jobs than any other major industry group...approximately 91,400 new jobs in the private health care system in Ohio from 2004-2014.”¹²³ Interestingly, while there was a 3.2 percent decline in the number of all hospitals in Ohio from 2000 to 2006, the number of employees increased by 12.6 percent and the average wage increased by 29.5 percent.¹²⁴ Ambulatory health care services experienced a 6.8 percent increase in the number of establishments that resulted in a 18.2 percent increase in the number of employees who received on average a 15 percent raise in their wages.¹²⁵ While most other major industries in Ohio experienced at best a modest increase in wages, or more likely a decline in wages, the healthcare industry overall experienced the highest average increase in annual wages.¹²⁶ The projection is that healthcare occupations will grow by nearly 20 percent over the decade from 2004 to 2014, while non-health care occupations will have a modest 5.9 percent growth.¹²⁷

The growth in new jobs represents a significant piece of the entire employment need. The filling of positions vacated due to retirement and other anticipated reasons are another critical piece of the employment need. The estimate is that there will be an

¹²¹ Keith Ewald, “Ohio Health Care Employment: Labor Market Trends and Challenges,” Office of Workforce Development, Ohio Department of Job and Family Services, 2008, p. 2.

¹²² *Ibid.*, p. 5.

¹²³ *Ibid.*, p. 6.

¹²⁴ *Ibid.*, p. 7.

¹²⁵ *Ibid.*, p. 6.

¹²⁶ *Ibid.*, p. 10.

¹²⁷ *Ibid.*, p. 12.

average of 22,176 health care openings annually in Ohio through 2014. Nearly half (48 percent) of these openings will be to replace professionals currently in these positions.

¹²⁸ The aging of the work force in Ohio within the health care field is a problem across all facets of the industry including the mental health field. With an aging population in general, there is an increased need for health care workers in general, in addition to the need caused by the retirement of the health care workers.¹²⁹

While the overall outlook for healthcare occupations looks promising, within the mental health field, the lack of reimbursement parity for mental health treatment compared to other health-related issues has an impact on the ability to recruit and retain competent mental health professionals.

The training and education needs of future healthcare workers is a critical factor if there are to be sufficient trained staff to meet the need created by attrition and by overall demand for healthcare services. In the following sections, we will discuss the present status of key mental health professions that serve people with mentally illnesses.

Psychiatrists

The 2004 Report, *Crisis in Ohio's Acute Mental Health Care*, cited the status of some of the major mental health professions. It stated, "Psychiatrists today are choosing not to do inpatient acute care as time commitments and reimbursement have become an issue. Many prefer the 8 a.m. to 5 p.m. schedule of outpatient private practice over the complexity of care and 24-hour responsibility of inpatient care. The amount of time involved has increased as the number of psychiatrists has decreased."¹³⁰ The 2004 Report noted that psychiatrists are also rejecting the burdensome administrative activities involved with reimbursement for services. Many psychiatrists choose to "leave their practice rather than deal with the 'red tape' associated with reimbursement."¹³¹

The 2004 report noted that "Residency programs at hospitals have fewer slots available for interested physicians or have closed their programs along with their psychiatric units. Consequently, some facilities have resorted to employing 'hospitalists' to oversee inpatient psychiatric care. This does not bode well for the future of the practice of psychiatry by qualified practitioners."¹³²

The 2004 Report stated that, "the distribution of all psychiatrists in Ohio finds the highest concentration in large urban settings. Eight counties report four or more psychiatrists per 20,000 residents, 33 counties report two to three psychiatrists per 20,000 residents, and 47 counties report zero to one per 20,000 residents."¹³³ The report's sobering conclusion was that "these numbers suggest that clients may have

¹²⁸ Ibid., p. 12.

¹²⁹ Ibid., p. 22

¹³⁰ ODMH, *Crisis In Ohio's Acute Mental Health Care Report*, p. 14.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Ibid.

difficulty in scheduling an appointment with a psychiatrist either prior to or following an inpatient stay, thus affecting the quality of mental health care in Ohio.”¹³⁴

On the national scene, the most recent studies available indicate several stark concerns regarding psychiatry. The 2006 Substance Abuse and Mental Health Services Administration (SAMHSA) Report on Mental Health Practitioners and Trainees cited that while there had been a 38 percent increase in the number of psychiatrists from 1983 to 2002, “the rate of growth has slowed in recent years. In fact, the rate of growth from 2000 to 2002 was less than 1 percent.”¹³⁵ The SAMHSA report further noted that in 2002, “the median age of female and male APA [American Psychiatric Association] member psychiatrists was 49 and 57, respectively. Approximately 53 percent of female APA members are under age 50, compared with 29 percent of male APA members.”¹³⁶

According to the SAMHSA report, “Data indicate that the psychiatric workforce in general continues to age, with 64 percent of clinically trained psychiatrists having completed their highest professional degree more than 21 years ago.”¹³⁷ Most alarming is the fact that at the other extreme only two-tenths of one percent (0.2 percent) of psychiatrists have less than five years of experience.¹³⁸ The decline in the number of psychiatrists and their relative age is reflected in the membership to the American Psychiatric Association. The SAMHSA Report cited that “Over the past decade, APA membership has declined, specifically for younger psychiatrists. For example, in 1990 psychiatrists under age 45 constituted 37 percent of the APA membership, but by 2002 that number had dropped to 21 percent. Other data corroborate the aging of the psychiatric workforce as well.”¹³⁹

The American Medical Association stated that in 2004, “psychiatrists under age 45 constituted 46 percent of the psychiatric workforce in 1990 and only 30 percent in 2002.”¹⁴⁰ See Figure No. 65 on the next page. Possibly most disconcerting is that one-third of the male psychiatrists are at least 65 years of age. Nearly a quarter of the male psychiatrists are 70 years old or older.¹⁴¹ Among female psychiatrists, only 12.8 percent are older than 64 years of age.¹⁴² However, considering that men comprise 72 percent of all the psychiatrists,¹⁴³ clearly the “graying” of the field of psychiatry does not bode well for the future of this proud medical profession.

¹³⁴ *Ibid.*

¹³⁵ Farifteh F Duffey, et.al., “Mental Health Practitioners and Trainees-Psychiatry”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 4.

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*, p. 5.

¹³⁸ *Ibid.*, Table No. 22-4.

¹³⁹ *Ibid.*, p. 5.

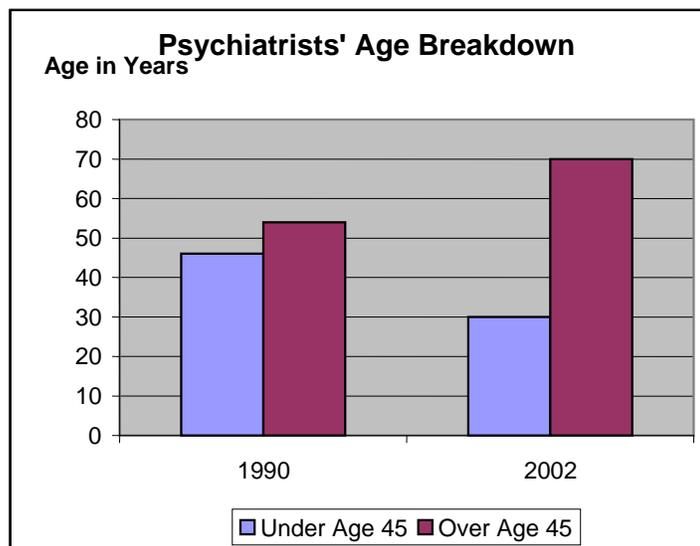
¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*, Table 22.2.

¹⁴² *Ibid.*

¹⁴³ *Ibid.*

Figure No. 65.



Source: SAMHSA National Mental Health Information Center, American Medical Association

While the demand for services is ever increasing if for no other reason than the increase in population, the number of psychiatrists who will be available to treat the demand is dwindling. Reimbursement issues remain a likely significant disincentive for young doctors when choosing a field of specialty. Comparable salary may be another consideration. On average in Ohio, the 2007 hourly wage for a psychiatrist was \$73.63. This wage compares unfavorably with nearly all the other medical professions that require a M.D. or D.O. degree. For example, the average hourly wage for a surgeon was \$93.41. General Internists and Pediatricians on average earn a dollar or so more an hour than do psychiatrists.¹⁴⁴ Psychiatrists only earn more than Podiatrists.¹⁴⁵

The SAMHSA report noted that with respect to psychiatric trainees, “during the 1980s, the number of medical students entering psychiatric residencies increased by almost 25 percent, data from the APA annual census of residents indicate that during the 1990s, this growth plateaued. The 2002-03 data indicate a decrease of about 8 percent in the total number of residents since the mid-1990s.”¹⁴⁶ The only silver lining on this trend is that the “steady increase in the proportion of female residents continues. In 1998-99, 53

¹⁴⁴ Keith Ewald, p. 28.

¹⁴⁵ *Ibid.*

¹⁴⁶ Farifteh F Duffey, et.al., “Mental Health Practitioners and Trainees-Psychiatry”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, Table 22-2.

percent of psychiatric residents were male and 47 percent were female, compared with 56 percent and 43 percent, respectively, in 1990-91 (one percent missing data).¹⁴⁷

Another significant problem in the field of psychiatry is the under-representation of minority populations. Nearly three-fourths of psychiatrists are identified as White (not Hispanic). Asian/Pacific islander comprises the second largest racial group among psychiatrists. At the same time less than 10 percent are Hispanic and less than 5 percent are African-American. The disparity is especially acute among the African-American males who comprise less than two percent of all male psychiatrists.¹⁴⁸ The disconnection between the racial composition of the psychiatrist pool and the treating population remains a significant matter to be addressed through cultural competency as well as recruitment initiatives.

The graying of the profession and the decline in the number of psychiatric residents are not the only factors negatively impacting on the profession. More than one-half of psychiatrists are practicing in multiple settings.¹⁴⁹ They are also involved in a multitude of responsibilities in addition to providing patient care. While 94 percent acknowledged being involved with patient care, the psychiatrist also noted that 85 percent were also involved in administration, and 20 percent were involved in research. The report found there had been a decrease in patient care hours while the amount of hours devoted to administrative matters had increased. For example, "Psychiatrists spent a mean of 26.1 hours per week or 60 percent of their work week in direct patient care in 2002, compared to 67 percent in 1988. In addition, psychiatrists appear to have spent 8.7 hours per week in administrative activities in 2002, up from 5.8 hours per week in 1988."¹⁵⁰ The report posited that "the decrease in direct patient care hours and increase in administrative hours during this period may be due to changes in the organization and financing of the Nation's health care system."¹⁵¹

Moreover, SAMHSA's 2006 Report noted that only 11 percent of full-time psychiatrists were working in hospital settings. The majority of full-time psychiatrists were either in individual practice (34.5 percent) or clinics (30 percent.)¹⁵² The report theorized that "Previously, hospitals have been one of the major work settings for psychiatrists, but substantial changes in the health care delivery system may have resulted in a decline in the proportion of psychiatrists primarily working in hospitals."¹⁵³ The 2006 Report rendered a sober conclusion not all that different from the 2004 *Crisis in Acute Care* Report's assessment. The 2006 Report concluded, "Research has shown that psychiatrists treat a patient population with more severe and complex problems than other general medical and mental health providers... Analyses of the National Medical Expenditure Survey data indicate that compared with psychologists, psychiatrists tend to see a larger proportion of persons who are socially disadvantaged, who report that

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*, Table 22.5.

¹⁵⁰ *Ibid.*, p. 6.

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*, table 22.6.

¹⁵³ *Ibid.*, p. 6.

their health interferes with their work, and who have higher utilization of non-hospital outpatient mental health care. In addition, psychiatrists provided significantly more visits than psychologists for schizophrenia, bipolar disorder, substance abuse and depression, but fewer visits for anxiety disorders and isolated symptoms. As the U.S. health delivery system evolves and the demand for psychiatric services increases, it will be increasingly important to track and understand the characteristics of the psychiatric workforce as well as the populations it serves.”¹⁵⁴

The Ohio Department of Mental Health has embarked on a strategic plan to aid in the recruitment and retention of a highly qualified psychiatric staff. In 1992, then Director Michael Hogan convened a task force to examine the issues regarding the recruitment and retention of psychiatrists. The task force recommended “sweeping changes in the critical areas needed for the attraction and retention of qualified psychiatrists, including those changes relevant to salary, benefits, continued education, university teaching and training affiliations, etc.”¹⁵⁵

In 2005-2006, a new task force examined the present state of psychiatrist recruitment and retention and made revised recommendations. Among the findings in 2006 was a relatively low overall vacancy rate of just over three percent (3.26%). Nearly two-thirds of the psychiatric staff was now certified by the American Board of Psychiatry and Neurology.¹⁵⁶ The 2005-2006 task force submitted 17 new recommendations to assist with recruitment and retention. The recommendations covered salary adjustments to keep salaries competitive with those offered by community agencies; increased compensation for after-hours on-duty coverage; establishment of a reimbursement process to facilitate the psychiatric staffs’ participation in required CME [Continuing Medical Education] activities; a task force to “improve the respect given to and the morale of psychiatrists...”; consider advocating for shortening the service requirement for psychiatrists to reach retirement eligibility; and to benchmark salary and benefits with “data from Community Mental Health Providers and public psychiatric hospitals from contiguous states.”¹⁵⁷

Clinical Psychologists

Since World War II, clinical psychologists have been increasingly involved in providing mental health services. The profession experienced a marked increase in numbers in the 1970s as state regulatory agencies were developed following statutory recognition of the profession.¹⁵⁸ The profession gained further status with the generally agreed upon standard that a doctorate was essential to practice in the mental health field. By 2004, there were at least 85,000 psychologists nationally, a four-fold increase in just

¹⁵⁴ Ibid.

¹⁵⁵ Doug Smith, et. al., *Strategies for Maintaining Quality Psychiatric Staffing in the Integrated Behavioral Healthcare System: Recommendations for Salary and Benefits for Fiscal Years 2007-2009*, ODMH, January 2006, p. 4.

¹⁵⁶ Ibid., p. 5.

¹⁵⁷ Ibid., pp. 16-17.

¹⁵⁸ Jessica Kohout and Marlene Wicherski, “Mental Health Practitioners and Trainees-Psychology”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 7.

over 25 years.¹⁵⁹ Psychologists can be found in “every type of mental health setting, including those that are research or treatment-oriented and general primary health care or specialty focused (e.g., sports and other injuries, elderly, seriously mentally ill). Given these more diversified workplaces, the roles of psychologists also have diversified and become more complex. In addition to the assessment and treatment of individual clients, psychologists now are involved in prevention, intervention at the community level, assessment of service delivery systems (outcomes), and client advocacy.”¹⁶⁰

A significant factor in the growth of doctoral-level psychologists has been the expansion of the training programs during the past 20 years. In 1979, there were only 134 programs in the United States. In 2004, the number of programs had nearly tripled to 369 doctoral programs. Along with the expanded number of programs has been the increase in the number of doctoral candidates. From the 1984-1985 biennium (14,586) to 2004-2005 (26,151) the number of students nearly doubled.¹⁶¹

Yet, despite the exponential growth in the number of psychologists, the SAMHSA 2006 Report cautions that shortages exist in the number of doctoral-level psychologists who are providing direct services. Psychologists are “relatively inaccessible in many areas of the country, and shortages of mental health personnel exist for certain target populations. These populations include seriously emotionally disturbed children and adolescents, adults with serious mental disorders, rural residents with mental health needs, and the elderly, to name a few.”¹⁶²

The aging factor is less acute in psychology than in psychiatry. Women comprise a slight majority of the psychologists, and only 10.5 percent are over 65 years of age. Among male psychologists, 22.2 percent are over 65 years of age. The primary age cluster for psychologists is in their fifties.¹⁶³ In Ohio, in 2000, 42.8 percent of psychologists were identified as between the ages of 45 and 55.¹⁶⁴

The financial compensation for doctoral level psychologists is an additional consideration. The average hourly wage in 2007 for clinical, counseling and school psychologists was \$37.46. While this compensation is higher than any other profession traditionally in the mental health field outside of psychiatrists, the pay compares unfavorably to other occupations that require a first professional degree. Psychologists earn less than any other of the healthcare professions that require a first professional degree, except for audiologists.¹⁶⁵

Also, whereas nearly two-thirds of psychiatrists had more than 21 years of experience following their formal training, only one-third of psychologists has more than 21 years of

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*, pp. 7-8.

¹⁶¹ *Ibid.*, p. 8.

¹⁶² *Ibid.*

¹⁶³ *Ibid.*, Table 22.2.

¹⁶⁴ Keith Ewald, p. 13.

¹⁶⁵ *Ibid.*, p. 28.

experience following their graduation from the doctoral program.¹⁶⁶ Just under half of the clinical psychologists (47.3 percent) had between six and 20 years of experience.¹⁶⁷ A little over 14 percent of licensed psychologists had less than five years of experience post degree; the second highest percentage of the mental health professions commonly found in mental health hospitals or mental health clinics.¹⁶⁸ The overall younger group of psychologists coupled with the growth in the number of doctoral students and the number of doctoral programs would seem to bode well for the psychology profession at least for the short term, nationally.

The racial composition of psychologists is even less diverse than for psychiatrists. Over 90 percent are identified as White (not Hispanic). Less than three percent of psychologists are listed as Hispanic or as African-American.¹⁶⁹ As with psychiatry, the disconnection between the racial composition of the psychologist pool and the treating population remains a significant matter to be addressed through cultural competency as well as recruitment initiatives.

The SAMHSA Report found that nearly 90 percent of doctoral-level psychologists who were trained to provide direct treatment services are in fact doing so. The majority of the psychologists (52 percent) practice in either individual or group private practice. Another, 30 percent are providing services in an academic setting. Only nine percent are practicing in a hospital setting. Of that number, only three percent are treating patients in mental hospitals. Only six percent of psychologists are practicing in an out-patient clinic or out patient mental health setting.¹⁷⁰ Thus, most of the psychologists are not practicing in settings that are more likely to serve the more severely mentally ill populations. In addition, as with psychiatrists, nearly half of the psychologists practice in more than one setting. Many are involved in activities other than direct clinical practice. The SAMHSA Report found that “about one-fourth conduct research; almost 39 percent provide some type of education (usually in higher education); more than one-third reported managerial or administrative responsibilities; and about 39 percent mentioned other employment activities (such as publishing or writing) not captured by these categories.”¹⁷¹

The Ohio Psychological Association, a member organization of approximately one-half of the licensed psychologists in Ohio, noted that 9.8 percent of their members identified practicing in a hospital setting, and 14.8 percent identified a public sector location of practice.¹⁷²

¹⁶⁶ Jessica Kohout and Marlene Wicherski, “Mental Health Practitioners and Trainees-Psychology”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center 2006, Table 22.4.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ *Ibid.*, Table 22.2.

¹⁷⁰ *Ibid.*, Table 22.6.

¹⁷¹ *Ibid.*, p. 9.

¹⁷² Bobbie Celeste, Ph.D., Ohio Psychological Association, membership database, 2010.

Licensed Social Workers

In Ohio, the profession of social work has been regulated by a licensure board since 1986. Ohio has joined all the other states in regulating the practice of social work.¹⁷³ The 2006 SAMHSA Report noted that “the number of clinically trained social workers continues to grow as the largest professional group of mental health and therapy services providers.”¹⁷⁴ The Report cited National Association of Social Workers (NASW) membership data that indicated there were 103,128 clinically trained social workers in 2004.¹⁷⁵ However, that number is underreported, as many social workers who are licensed choose not to also be members of the profession’s national organization.

The SAMHSA Report also found that there “has been a steady increase in the number of MSW [Masters of Social Work] degrees awarded—up by nearly 50 percent.”¹⁷⁶ The MSW degree qualifies social workers trained in the clinical field to “provide a wide range of social work services—therapy, case management, advocacy, education, teaching and [they] are eligible for licensure or registration in every State.”¹⁷⁷

Unlike the field of psychiatry, the field of clinical social work remains dominated by female social workers who comprise 82 percent of the work force. Similar to the fields of psychiatry and psychology, social work is predominately practiced by White (not Hispanic) practitioners who comprise 87 percent of the professionals.¹⁷⁸ While the percentage of clinical social workers who are African-American (4.5 percent) or Hispanic (2.8 percent) is slightly higher than the breakdown for psychiatrists and psychologists,¹⁷⁹ the percentage is significantly below the population breakdown and the treatment population. As with the other two professions, the disconnection between the racial composition of the licensed social worker pool and the treating population remains a significant matter to be addressed through cultural competency and recruitment initiatives.

The ‘graying’ of the social work field is less pronounced than for psychiatrists or psychologists. More social workers fall in the 45 to 54 age bracket than any other age group.¹⁸⁰ More than a third of the social workers have more than 21 years of experience since their graduate work. The majority of social workers (52 percent) have

¹⁷³ Tracy Whitaker and Nancy Bateman, “Mental Health Practitioners and Trainees-Social Work”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 11.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.; Ibid., Table No. 22-8.

¹⁷⁷ Ibid.

¹⁷⁸ Ibid., Table No.22-2.

¹⁷⁹ Ibid.

¹⁸⁰ Ibid.

between six and twenty years of experience.¹⁸¹ The survey reported that 10.4 percent of social workers had less than five years of experience.¹⁸²

The primary places of employment for clinical social workers are outpatient clinics (22.9 percent) with mental health clinics being the primary location (17.6 percent). Another 18.5 percent of clinical social workers reported being engaged in private individual practice. Fewer than eight percent of social workers were practicing in hospital settings, which were equally split between mental health and other hospital settings.¹⁸³ Within these settings, the majority of the social workers (61 percent) identified direct patient care as their primary duty.¹⁸⁴

For social workers in the mental health field, the financial compensation may be a deterrent. In Ohio, the average hourly wage in 2007 for master's level trained social workers in the mental health or substance abuse field was \$17.94. The wage is \$2.50 lower than the average hourly wage for medical and public health social workers who possess only a bachelor's degree in social work.¹⁸⁵ The average wage for mental health and substance abuse social workers is also the lowest among health care professions that require a master's degree.¹⁸⁶

The profession of social work will continue to be the largest number of mental health providers for the foreseeable future. The social worker population as a whole is younger than the fields of psychiatry and psychology. If the present available data continues, the graduate-level social work programs will deliver both an increasing number of social workers into the field as well as a more culturally diverse workforce. The SAMHSA Report cited a 2001 study that showed for the period 1998-1999, nearly one-fourth of the social workers who graduated were people of color.¹⁸⁷

Psychiatric Nurses

The 2004 *Crisis in Ohio's Acute Mental Health Care* Report noted that "the number of psychiatric nurses also has a profound effect on inpatient capacity. Nationwide, there is a growing nursing shortage in all practice areas, including mental health, and Ohio reflects this trend. Recruitment and retention of registered nurses is critical to the functioning of an inpatient psychiatric unit. The Ohio Department of Mental Health licensing rules mandate staffing requirements. Therefore, if a facility has difficulty recruiting and/or retaining qualified professional staff, the number of beds that can be used may need to be reduced."¹⁸⁸

¹⁸¹ Ibid., Table No. 22-4.

¹⁸² Ibid.

¹⁸³ Ibid., Table No. 22-6.

¹⁸⁴ Ibid., Table No. 22-7.

¹⁸⁵ Ewald, p. 28.

¹⁸⁶ Ibid., p. 28.

¹⁸⁷ Tracy Whitaker and Nancy Bateman, "Mental Health Practitioners and Trainees-Social Work", *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 12.

¹⁸⁸ ODMH, *The Crisis in Ohio's Acute Mental Health Care* Report, 2004, p. 14.

The 2006 SAMHSA Report stated that “the current psychiatric nurse workforce practices in a variety of roles and is a core discipline in mental health care delivery systems across all levels of care. The work force includes registered nurses with basic nursing education who are working in psychiatric mental health settings, referred to... as psychiatric registered nurses (PRNs); and registered nurses with master’s and/or doctoral degrees with graduate education in psychiatric mental health conditions, referred to as psychiatric mental health advanced practice registered nurses (PMH-APRNs).”¹⁸⁹ The discussion of psychiatric nursing staffing will be subdivided into Psychiatric Registered Nurses and Advanced Practice Registered Nurses.

Psychiatric Registered Nurses

The 2006 SAMHSA Report estimated that “approximately 80,000 PRNs [Psychiatric Registered Nurses] are employees of hospitals and agencies providing mental health services.”¹⁹⁰ The report cited studies that estimated that nearly 50 percent of the PRNs are employed in “private, nonfederal psychiatric hospitals and general hospital psychiatric units.”¹⁹¹ The other half are employed in community based settings.¹⁹² The SAMHSA Report noted that the PRNs are as a whole, older than the registered nurses in the general population of the acute care hospitals. The average age of the PRN is 47 years old, three years older than their colleagues in other areas of nursing. Further, only 16.7 percent of PRNs are under the age of 39, compared with 27.7 percent of registered nurses in other fields.¹⁹³ See Figure No. 66 on the next page. Further, the report cited studies that indicate that fewer new registered nurses are choosing to enter into psychiatric nursing. The SAMHSA Report concluded soberly that the “data suggests that the workforce shortage of PRNs is more urgent than the national shortage of general RNs.”¹⁹⁴

¹⁸⁹ Nancy Hanrahan, et.al., “Mental Health Practitioners and Trainees- Psychiatric Nursing”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 14.

¹⁹⁰ *Ibid.*

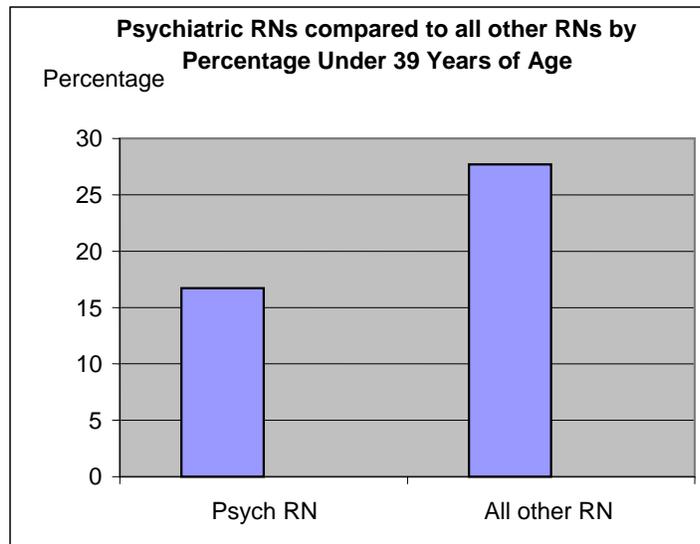
¹⁹¹ *Ibid.*

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

Figure No. 66.



Source: SAMHSA National Mental Health Information Center, 2006
2000 National Nurse Survey of Registered Nurses

According to the 2004 Report, “there are many reasons that nurses are not drawn to psychiatric nursing. One hospital nursing administrator suggests that the overall benefit package is an issue for all units when recruiting externally, stigma causes many nurses to avoid psychiatric nursing altogether. Short lengths of stay make many nurses feel as though they are not able to establish therapeutic relationships with their clients. The high rate of readmissions cause nurses to feel that they never make a difference in the treatment of mental illness. Perceived safety factors due to the severity and nature of some of the patients’ mental condition and behaviors can affect a registered nurse’s decision; however, many nurses like the low ratio of patients to staff on a mental health unit.¹⁹⁵ With the graying of psychiatric nurses and fewer registered nurses choosing psychiatric care as their specialty, issues of recruitment and retention will need concerted attention.

The 2006 SAMHSA Report stated that nursing in general and psychiatric nursing specifically remains a female-dominated profession. However, a greater proportion of PRNs are male (16.2 percent) compared to just 6.7 percent for general nursing.¹⁹⁶ The report also pointed out that psychiatric nursing has a better racial diversity than general nursing with White (non Hispanic) population of 82.4 percent and African-American population of 11.8 percent.¹⁹⁷

¹⁹⁵ ODMH, *The Crisis in Ohio’s Acute Mental Health Care Report*, 2004, p. 15.

¹⁹⁶ Nancy Hanrahan, p. 14.

¹⁹⁷ Ibid.

The SAMHSA Report further stated that “more than half of PRNs have an associate degree in nursing, and 24 percent report a baccalaureate degree....The majority of PRNs are employed full time (73 percent) in direct patient care, supervisory, and administration functions, suggesting that PRNs play a large role in the direct management and coordination of acute inpatient psychiatric care.”¹⁹⁸ The report also mentioned that “job turnover is higher for PRNs than general RNs. Most PRNs who changed jobs reported that they were attracted by a more interesting job or better opportunities.”¹⁹⁹

The implications of a ‘graying’ psychiatric nursing workforce that has a high turnover rate and fewer new nurses entering into the field are ominous. The SAMHSA Report stated that “there may not be enough registered nurses to staff environments that serve the most acutely ill clients.”²⁰⁰ Also, the trend toward a decline in psychiatric registered nurses may mean that there will be fewer nurses to recruit into the newer and promising field of advance practice psychiatric nursing.

Advanced Practice Psychiatric Mental Health Nurses

The Advanced Practice Psychiatric Mental Health Nursing (APRN) field grew out of the nursing practitioner field that began in the mid 1960s. APRN is a registered nurse who has advanced academic and clinical experience, which enables the APRN to “diagnose and manage most common and many chronic mental and physical illnesses, either independently or as part of a health care team. A PMH-APRN focuses clinical practice on individuals, families, or populations at risk for developing and/or having a diagnosis of psychiatric disorders or mental health problems across the life span.”²⁰¹ PMH-APRNs may prescribe medication in most states, including Ohio. Across the country there are 140 graduate level programs in nursing that offer mental health specialty preparation.²⁰²

The SAMHSA Report found that in 2004 there were an estimated 20,000 graduate trained advanced practice psychiatric nurses in the United States. Of this number, 8,751 were board certified by the American Nurses Credentialing Center. Three-quarters of board certified PMH-APRNs are employed full time. However, unlike undergraduate psychiatric nurses where around 16 percent were male, only five percent of the board-certified advanced practice nurses are male. Over 80 percent of the board-certified advanced practice nurses are White (non-Hispanic.) Less than four percent of the advanced practice nurses are African-Americans and less than three percent are Hispanic.²⁰³ As with the other mental health staff discussed so far, the disconnection between the racial composition of the board-certified advanced practice nurses pool and

¹⁹⁸ *Ibid.*

¹⁹⁹ *Ibid.*

²⁰⁰ *Ibid.*

²⁰¹ *Ibid.*, p. 15.

²⁰² *Ibid.*

²⁰³ *Ibid.*, Table. No. 22-2.

the treating population remains a significant matter to be addressed through cultural competency and recruitment initiatives.

The SAMHSA Report stated that “less than 3 percent of female graduate-prepared nurses are under age 35; in 1988, 18 percent were under age 35. This trend continues with the decline in percentages of nurses in the 35 to 39 and 40 to 44 age groups. The average age of female graduate-prepared psychiatric nurses was 55 years in 2003, up from 48 years in 1996. Four percent of male graduate-prepared nurses are under age 35, with an average age of 44 years in 2003.”²⁰⁴ The majority of the advanced practice nurses are between 45 and 60 years old.²⁰⁵ Two-thirds of the advanced practice nurses received their highest degree in nursing more than 10 years ago, while a quarter received their degree more than 21 years ago.

The SAMHSA Report noted that just over 13 percent of advanced practice nurses had less than five years of post degree experience.²⁰⁶ Thus, the ‘graying’ of the advanced practice nursing field is not as acute as in psychiatry or psychology, but given the ongoing demand for registered nurses, “the biggest employment challenge will be ensuring an adequate supply of registered nurses. This is the largest health care occupation, accounting for almost one out of every six health care jobs, as well as a fast-growing occupation with a high number of annual openings,”²⁰⁷ according to Ohio Department of Job and Family Services (ODJFS). In Ohio, the estimate is that nearly 30 percent (29.8%) of the registered nurses are between the age of 45 and 55.²⁰⁸ ODJFS predicts that there will be 4,630 annual openings for registered nurses in Ohio.²⁰⁹

On the national level, there is some reason to be hopeful as the SAMHSA Report noted that in 2003, “there were 1,550 enrollees in psychiatric mental health graduate programs...The number of graduates increased from 426 in 1997-98 to 460 in 2003. About 71 percent of graduates are prepared as psychiatric nurse practitioners (NP), which includes those educated in combined NP/clinical nurse specialist (CNS) roles, with 29 percent being prepared as CNSs...The recent proliferation of psychiatric nurse practitioner educational programs is producing a different nursing workforce than previously existed and may address the current shortage, as the number of nurses enrolled in these graduate programs is rising.”²¹⁰

However, in Ohio there is alarm that the educational system will be unable to keep up with the demand for registered nurses. ODJFS cautioned that “high-skill occupations tend to rely on structured training or educational programs for a supply of workers. The educational infrastructure of an occupation can affect its labor market. For example, the

²⁰⁴ *Ibid.*, p. 15.

²⁰⁵ *Ibid.*, Table No. 22-2.

²⁰⁶ *Ibid.*, Table No. 22-4.

²⁰⁷ Ewald, p. 14.

²⁰⁸ *Ibid.*, p. 13.

²⁰⁹ *Ibid.*

²¹⁰ Nancy Hanrahan, et.al., “Mental Health Practitioners and Trainees- Psychiatric Nursing”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, Table No. 22-2.

current educational infrastructure may not be able to produce enough RNs in the future because of faculty shortages. Education for registered nurses will need to consider both future job demand and the education structure.”²¹¹ A key impediment to a sufficient number of nursing school faculty is that “the nursing educator workforce is aging and the salaries of these educators is considerably lower than if they were to work in hospitals.”²¹²

As could be anticipated given the intense demand for registered nurses, the hourly wage compares favorably to other health care occupations that require a minimum of an associate degree. The average wage in 2007 for registered nurses was \$27.36, which ranks the profession fifth out of fifteen of the healthcare occupations requiring an associate degree. Nearly all the other related professions with higher wages are for specialty technicians.²¹³

An interesting difference between the advanced practice nurses and most other mental health professionals is the areas in the states where many choose to practice. The SAMHSA Report identified “A difference in health status between residents in rural and urban regions has prompted attention to the challenges facing rural health care and health care systems. One major issue is poor access to mental health services and a severe shortage in the mental health workforce associated with rural areas.”²¹⁴ The Report discovered that “according to a recent study of the rural mental health workforce, significant numbers of advanced practice psychiatric nurses choose to work in rural areas...Twenty states have at least 20 percent of their advanced practice psychiatric nurses in rural practice. Using a system for classifying rural areas based on census tract geography, population size, and commuting relationships, there are 3.11 advanced practice psychiatric nurses per 100,000 in the United States.”²¹⁵ However, at the same time, in the rural areas of some states the ratio is three times higher.

Unlike the psychiatrists and psychologists, most of the PMH-APRNs hold just one position in nursing. The PMH-APRNs work primarily in hospitals, private practice and mental health clinics.²¹⁶ The SAMHSA Report also concluded that “there are no significant changes from 1996 and 2000 in the distribution of nurses in various work areas except for a rising number of nurses in the “other” category, which may be due to an increase in employment opportunities in the managed care sector.”²¹⁷ The vast majority of the advanced practice nurses provide direct patient care (80.7 percent), followed by “other activities” (12.6 percent), and to a far lesser extent in administrative, teaching or research roles.²¹⁸

²¹¹ Ewald, p. 22.

²¹² *Ibid.*

²¹³ *Ibid.*, p. 27.

²¹⁴ Nancy Hanrahan, p. 14.

²¹⁵ *Ibid.*

²¹⁶ *Ibid.*, Table No. 22-6.

²¹⁷ *Ibid.*, p. 15.

²¹⁸ *Ibid.*, Table No. 22-7.

The SAMHSA Report identified “a critical workforce shortage area is child psychiatry. Four out of five children who need mental health services are not receiving them (U.S. Department of Health and Human Services, 1999). PMH-APRNs are trained to provide the full range of assessment and treatment services, including medications, to seriously emotionally disturbed youngsters. Currently, 1,200 PMH-APRNs are certified to treat children and adolescents. The current workforce of mental health nurse practitioners trained in child/family is expected to increase as a result of the recent opening of 15 new graduate programs.”²¹⁹ However, in Ohio the adult population is the primary treatment segment for PMH-APRNs.

Licensed Professional Counselors

In Ohio, there are two groups of counselors: Licensed Professional Counselor (LPC) and Licensed Professional Clinical Counselor (LPCC). Professional counseling is defined as the “application of mental health, psychological, or human developmental principles through cognitive, affective, behavioral, or systemic intervention strategies that address wellness, personal growth, or career development, as well as pathology.”²²⁰ Ohio joins nearly every other state in the licensing or certifying of master’s-level counselors.

Licensed counselors comprise the second largest number of mental health professionals in the United States, second only to social work. Nationally, there are more than 100,000 licensed counselors. The majority are female (78 percent), and similar to the other mental health professionals, there is an aging or ‘graying’ of the profession. The slight majority of the licensed counselors are between 50 and 64 years of age. However, unlike the other mental health professionals, over 15 percent of licensed counselors also comprise the under 35 age category.²²¹ In terms of post-graduate study, nearly a quarter of licensed counselors have 21 years or more of experience. At the opposite end, nearly 21 percent of licensed counselors had less than five years of experience; the largest percentage of any of the mental health professions.²²² Thus, it would appear that the danger of the ‘graying’ of the profession is less of an issue compared to the other mental health professions, especially psychiatry.

Another positive aspect of counselors is their average wage compensation. In Ohio, the average hourly wage in 2007 for master’s-level trained mental health counselors was \$19.84, which compares favorably to master’s-level trained social workers.²²³ However, compared to other health care professions that require a master’s degree, mental health counselors are in the lower third in terms of average wage.²²⁴

²¹⁹ *Ibid.*, p. 15.

²²⁰ Rex Stockton, et.al., “Mental Health Practitioners and Trainees- Counseling”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 17.

²²¹ *Ibid.*, Table No. 22-2.

²²² *Ibid.*, Table No., 22-4.

²²³ Ewald, p. 28.

²²⁴ *Ibid.*

In addition, reinforcements are on the way. The SAMHSA Report identified that “in 2004, more than 40,000 students were in training, the great majority in master’s programs, which they complete in 2 years...anecdotal numbers from training programs indicate that their enrollments are increasing, which will help offset the current small decreases in the numbers of professional counselors. Thus, it appears that there will be ample replacements for those who retire from the field.”²²⁵

As was the case with the other mental health professionals, a definite gap exists between the percentage of licensed counselors that are from minority cultures and the percentage that these cultures comprise in American society. According to the SAMHSA Report, “approximately 81 percent of the counselors currently practicing are White, compared with 5 percent African-American, 2 percent Hispanic/Latino, 1 percent Asian, and less than 1 percent Native American counselors.”²²⁶ As is the case with the other mental health professions, the SAMHSA Report concluded, “There is a need for an increasing number of counselors of various ethnic, racial, and religious backgrounds. Training programs are meeting the need for diversity by including courses on multiculturalism and other modes of training to expose counselors and students of counseling to a wide array of cultures, customs, and traditions so as to maximize their appreciation for and service to different cultures.”²²⁷

Unfortunately, this large and relatively young mental health profession is largely absent from mental health settings. Only 3.3 percent of licensed counselors practice in mental hospitals. The situation is better for mental health clinics where 18.7 percent practice. Counselors are more likely to be found in school settings.²²⁸

Marriage and Family Therapists

The Ohio General Assembly established licensure for Marriage and Family Therapists and Independent Marriage and Family Therapists in April 2003. On January 7, 2009, Governor Ted Strickland signed into law House Bill 427, which allows marriage and family therapists the right to diagnose and treat mental and emotional disorders. Once marriage and family therapists are added to the authorization rules for reimbursement, and the Centers for Medicare and Medicaid Services approves the rule, marriage and family therapists will be eligible to receive reimbursement for services provided at mental health agencies.²²⁹

The number of licensed marriage and family therapists are slowly growing in the state, but remain a small number compared to counselors or social workers. In 2009, licenses were granted to 17 marriage and family therapists and 12 independent marriage and

²²⁵ Rex Stockton, et.al., “Mental Health Practitioners and Trainees- Counseling”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 20-21.

²²⁶ *Ibid.*, p. 21.

²²⁷ *Ibid.*

²²⁸ *Ibid.*, Table No. 22-6.

²²⁹ Ohio Counselor, Social Worker, and Marriage and Family Therapist Board, *Marriage and Family Therapist Facts*, <http://cswmft.ohio.gov/mftFact.stm>.

family therapists. In 2008, 16 marriage and family therapists were licensed, and nine received independent licenses.²³⁰

Psychosocial Rehabilitation

The SAMHSA Report named psychosocial rehabilitation (PSR) as a rapidly growing approach to working with individuals with severe mental illness in the community. “PSR programs usually provide any combination of residential services, training in community living skills, socialization services, crisis services, residential treatment services, recreation services, vocational rehabilitation services, case management services, and educational services. In recent years, PSR has been identified as a necessary ingredient for maintaining persons with severe mental illness in the community. PSR services reduce hospitalization, increase employment, and increase the quality of life of persons served.”²³¹ The Report further noted that the focus of the psychosocial rehabilitation is “teaching individuals with severe mental illness the skills necessary to attain goals of their choice in the community and on developing innovative supports.”²³² PSR workers are found in nearly all the states (48 out of 50) as well as Guam and the District of Columbia.

Compared to the other mental health professions, there are fewer psychosocial rehabilitation workers in the United States. The SAMHSA Report identified just 9,437.²³³ The PSR workers are predominantly female (65 percent). The average age of PSR workers is 38 years. The majority of the PSR workers are younger than 40 years, with the largest percentage in the under 35 years of age category.²³⁴ Less than one percent of the PSR workers are older than 69 years. In terms of post-degree experience, over 40 percent have more than 21 years of experience. At the opposite end, 5.5 percent of PSR workers had less than five years experience. The average number of years of experience was 15. The SAMHSA Report noted that PSR workers possessing an advanced degree were in the field an average of eight years.²³⁵

In terms of cultural diversity, unlike the other mental health professions, there is a greater relationship between the percentages in the field of PSR and the general population. The PSR population is predominately White (70 percent), and

²³⁰ Ohio Counselor, Social Worker, and Marriage and Family Therapist Board, 2008 and 2009 Annual Reports to the Governor; <http://cswmft.ohio.gov/pubs.stm>.

²³¹ Laura Blankertz, “Mental Health Practitioners and Trainees- Counseling”, *Chapter 22, Mental Health, 2004 Index*, SAMHSA National Mental Health Information Center, 2006, p. 26-27.

²³² *Ibid.*, p. 27.

²³³ *Ibid.*, Table No. 22-2. It should be pointed out that the source of the data for the PSR workers is much older than for the mental health professions. The data is from a 1994 survey, and thus is less likely to be up to date and accurate than for the other professions.

²³⁴ *Ibid.*

²³⁵ *Ibid.*, Table No. 22-4.

approximately 21 percent are African-American, six percent are Hispanic, two percent are Asian, and less than half of one percent are Native American.²³⁶

The SAMHSA Report noted that “two percent of all PSR workers have a doctoral degree, 24 percent have a master’s degree, 38 percent have a bachelor’s degree, 13 percent have some college or an associate degree, and 22 percent have only a high school degree. Twenty-five percent of PSR workers with bachelor’s degrees are currently working to attain a master’s degree. Among PSR workers with master’s or doctoral degrees, 24 percent have degrees in psychology, 36 percent in social work, four percent in psychiatry, three percent in counseling, and three percent in education. Sixteen percent have licenses or certificates in social work; 8 percent are certified as counselors; six percent are certified as teachers; and three percent are certified as addiction counselors.”²³⁷ The PSR are more likely to be cross-trained than the other professions. The profession is growing in its recognition as a valued mental health profession as evidenced by the fact that “academic programs have developed that specialize in PSR or include PSR as a specialized part of their curriculum. Currently, there are 13 Ph.D. programs, three combined M.D. and Ph.D. programs, 10 master’s level programs, one bachelor’s program, and one associate program in PSR. The number of programs is expanding rapidly as the field grows.”²³⁸

The SASMHA Report concluded that psychosocial rehabilitation continues to develop in terms of numbers and enrollment, and also in terms of its legitimacy as a bon-a-fide mental health profession. The SAMHSA Report highlighted that the profession’s international governing body, the International Association of Psychosocial Rehabilitation Services (IAPSRs), is working “closely with the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission for Accreditation of Health Care Organizations, the Council on Accreditation, and the Leadership Council in developing its guidelines. These guidelines were created by experts in the field on the basis of research and were validated by a field review by practitioners. The guidelines describe psychiatric rehabilitation approaches and interventions that are responsive to individual needs and desires and enhance recovery. Included are such areas as assessment, rehabilitation planning, skills teaching in all areas of functional limitations, facilitation of environmental supports, encouraging participation in community support and social activities, mental illness management, cognitive interventions, and methods of working with co-occurring disabilities. IAPSRs has also developed a code of ethics for its practitioners, with a process of adjudication for violations.”²³⁹

The SAMHSA Report concluded that, “the body of research literature that supports the efficacy of PSR has been growing rapidly as its importance in the management of severe mental illness has become firmly established. Psychosocial interventions are reported in many different journals and books. IAPSRs has also taken the lead in

²³⁶ Ibid., Table No. 22-2. The data is based on the distribution for the male PSRs. The female PSR cultural breakdown was not included in the report.

²³⁷ Ibid., p. 27.

²³⁸ Ibid., p. 27-28.

²³⁹ Ibid., p. 28-29.

developing a set of outcomes measures to be used by agencies in the field. These measures, which look at many domains of a person's life, have been incorporated into the data sets of other types of rehabilitation.²⁴⁰

In Ohio, there exists many fields of psychosocial rehabilitation and as many salary ranges which can practice in mental health settings. At the higher end are occupational therapists whose average hourly wage in 2007 was \$32.42. Rehabilitation Counselors' average hourly wage was \$20.45 and recreation therapists' \$19.29.²⁴¹

Psychiatric Aides and Community Psychiatric Support Treatment (CPST) Providers

The backbone of any mental hospital is the psychiatric aide who works on the units providing direct care and administering to the needs of the patients. In Ohio during 2004, there were 1,060 psychiatric aides. The projection in the coming decade is for only slight growth in the need for a net increase of 120 aides. The average annual openings are only estimated at around 26. In 2007, the average hourly wage was \$10.74, which was comparable to the wages of similar health care occupations that are categorized as requiring a short term of on the job training.²⁴² The hourly wage is lower than the average for nursing aides, orderlies and attendants who generally are considered to need a post-secondary vocational award for employment.

Mental Health Community Psychiatric Support Treatment (CPST) providers deliver a critical service in caring for the person with mental illness in the community. The education requirement varies, as do the average hourly wages. For CPSTs who are classified as psychiatric aides, their wages will be similar to the wage previously cited. If they are required to have a bachelor's or master's degree, their compensation may range from around \$17 an hour.²⁴³

Part V Work Force Key Points

1) A 2006 SAMHSA Report titled, "Highlights of Organized Mental Health Services in 2002 and Major National and State Trends" summarized the trend and shift in the staffing of mental health organizations. The Report noted, that "accompanying trends in the number of mental health organizations and their caseloads since 1970 has been an increase in the number of FTE staff these organizations employ. Increases occurred among the professional patient care staff, notably in the number of psychiatrists, psychologists, social workers, registered nurses, and other mental health professionals. The number of professional staff has more than doubled compared with a six percent increase in administrative, clerical and maintenance (support) staff and a 30 percent increase in other mental health workers (paraprofessional) staff. This increase in staffing can be attributed in large part to the expansion of community-based mental

²⁴⁰ Ibid., 29.

²⁴¹ Keith Ewalt, p. 27-28.

²⁴² Ibid., p. 27.

²⁴³ Ibid., p. 28.

health care services during this period, which has led to a greater emphasis on short-term hospital and residential care. The increase in staffing is also due to the development of less than 24-hour care and partial-care services, with the primary goal of keeping clients functioning in their own communities.

A feature of the contemporary evolution of health care service has been the replacement of higher cost professionals, particularly physicians, with other staff in less expensive labor categories, such as registered nurses. While the overall number of FTE staff in all mental health organizations increased in the 28 years between 1972 and 2000, the number of psychiatrists serving these mental health institutions increased at a slower rate than other professional staff. Between 1972 and 2000, the number of psychiatrists increased by 56 percent and the number of other physicians decreased by 26 percent. In contrast, the number of psychologists doubled, and the number of social workers nearly tripled.”²⁴⁴

2) The aging or ‘graying’ of many of the mental health professions is a significant issue. The problem is especially acute in the field of psychiatry. The present shortage of psychiatrists is likely to worsen as the large numbers of elderly psychiatrists retire and there are insufficient numbers entering the field to replace them. The ‘graying’ problem is also present in the fields of psychology, social work, and nursing though to a lesser degree than psychiatry. The only fields that appear to be in good shape due to an overall younger membership and increased academic enrollments are the counseling and psychosocial rehabilitation disciplines.

The issue of the ‘graying’ of the fields is not only related to age, but also in terms of the percentage of the disciplines who have years of experience since attaining their requisite degrees. This measurement further reinforces the concerns that insufficient numbers of new mental health professionals are entering the field to replace those that are likely to leave the field in the near future, let alone meet the growing need for services.

3) Cultural diversity is a significant concern in all the mental health fields. The only field that approximates the general population’s diversity is the field of psychosocial rehabilitation. The need for greater attention to recruitment, training and retention in the mental health fields among minority cultures is an ongoing concern.

4) There is a need for improved data collection at the state level among the regulatory bodies and professional associations. Data collection would ideally mirror the national level information to assist in Ohio having a clearer understanding of statewide trends.

²⁴⁴ Daniel J. Foley, et.al., “Highlights of Organized Mental Health Services in 2002 and Major National and State Trends”, Chapter 19, Substance Abuse and Mental Health Services Administration, 2006.

Part VI

Measures of Service Integration within the Mental Health System

Part VI

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Service integration within the mental health system primarily involves examining the critical stages in a client's care when the client is moving from one locus of care to another; in other words the "hand offs." Within the concept of access to acute care issues the primary focus is on the elements that reflect the level of transitioning of the client from the community treatment environment to an inpatient setting, and then back again to reside in the community. The two hand-off points are potential areas for the 'ball to be dropped' which can result in miscommunication or even disruption of the continuity of treatment.

In recognition of the need for consistent and streamlined communication during the hand off times, the Joint Commission on Accreditation of Healthcare Organizations developed the ORYX® initiative to measure the efficacy of communication between inpatient providers and post-discharge providers. The Hospital Based Inpatient Psychiatric Services (HBIPS-7) measure set: Post Discharge Continuing Care Plan transmitted to the next level of care provider upon discharge has two continuing care plan measures that assesses the strength of the hand offs. The initiative measures four dimensions of the continuing care plan, including: discharge diagnosis, discharge medications, reason for hospitalization, and recommendations for next level of care. The measure examines the extent which these four dimensions are consistently reflected in the continuity of care planning documents. The measures also look at the timeliness of communicating this information to the next treatment provider. The ORYX® standard is the transmission by the inpatient provider of the required information to the next treatment provider by the fifth day following discharge from the inpatient provider.²⁴⁵

The 2004 Report devoted a significant amount of discussion to the need for greater service integration within the mental health system. The Report noted that with respect to continuity of care, clients have a more difficult time accessing needed services. Dale Svendsen, M.D., the ODMH Medical Director at the time related, "I frequently hear comments like it takes six weeks or longer for a psychiatric appointment at a mental health center. For the most part, the problem seems to stem from fiscal constraints. Government, the private mental health system and all stakeholders need to be aware and take action."²⁴⁶

The Ohio Administrative Rule states that inpatient psychiatric service providers, albeit private or state-operated, "shall provide interim aftercare services for up to two weeks

²⁴⁵ Joint Commission, *Specification Manual for National Inpatient Quality Measures-Hospital-Based Inpatient Psychiatric Services Core Measure Set Version 2.1.b*, Release: March, 2009.

²⁴⁶ ODMH, *Crisis In Ohio's Acute Care Report*, 2004, p. 16.

post discharge, unless the aftercare provider assumes responsibility for the provision of aftercare services prior to the end of the interim two-week period. This shall include an appointment for medication management as needed. Such interim aftercare services shall include a crisis management plan, which may include a mechanism to contact a physician, interim medication management, referral to or provision of a support group or individual supportive services, or a mechanism to contact an emergency services provider.”²⁴⁷

The Administrative Code further outlines that the inpatient psychiatric service provider “shall determine, in collaboration with the patient and aftercare provider, that the aftercare provider has the appropriate services the patient has been identified as being in need of to include the provision of in-depth patient education regarding the nature and management of the patient’s illness/disorder.”²⁴⁸

The intent of the above code is to assure that, at a minimum, a discharged patient is provided essential services during the critical “hand-off” from an inpatient provider to a community provider. A hospital stay is generally considered a crisis or untoward event in the patient’s recovery; as such, continuity of care is especially critical immediately following a hospitalization. A critical measure of the integration of mental health services is how well a system of care complies with the requirements of the Ohio Administrative Code §5122-14-12, T, 1 (a).

Ambulatory Care Services

The 2004 Report noted that in a survey conducted by the Ohio Ambulatory Behavioral Healthcare Association that there was a declining use of ambulatory mental health programs while at the same time the demand for inpatient psychiatric services was increasing with “high inpatient re-admission rates and mushrooming emergency department visits.”²⁴⁹

The 2004 Report noted that partial hospitalization programs in particular were underutilized.²⁵⁰ The report noted that a major cause of this reduction was due to the reluctance of insurance companies and managed care entities to approve partial hospitalization.²⁵¹ Interestingly, a 2001 analysis of 16 studies have found that the outcomes for patients in partial hospitalization programs and those treated inpatient were no different, and that patients reported better satisfaction within one year of discharge.²⁵² Of course, not all patients can be treated safely in an out-patient setting as their individual needs may require inpatient services.

²⁴⁷ Ohio Administrative Code 5122-14-12, T.1 (a).

²⁴⁸ Ibid., (b).

²⁴⁹ ODMH, *Crisis In Ohio’s Acute Care Report*, 2004, p. 16.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Marcela Horvitz-Lennon, et. al. “Partial versus Full Hospitalization for Adults in Psychiatric Distress: A Systematic Review of the Published Literature (1957-1997), American Journal of Psychiatry: 158:5, May 2001, pp. 676-685.

A recent NIMH-funded multi-state study conducted by the University of South Carolina may provide further substantiation of the value of partial hospital programs in reducing the need for inpatient hospitalization. The yet to be published study found that partial hospitalization programs along with psychiatric expertise in the emergency departments could reduce the number of inpatient admissions.²⁵³

Unfortunately, partial hospitalization services are sometimes confused with psychiatric day care treatment, and many times considered synonymous. Partial hospitalization is generally affiliated with a hospital setting and can involve treatments up to seven days a week. Day treatment is generally provided by a community based, non-hospital agency. Partial hospitalization programs can include psychiatric, psychological, social and vocational services under the supervision of a psychiatrist. The program is designed for patients who do not require 24-hour inpatient services, but can still benefit from the array of services offered on an inpatient unit. Often, there are specific minimum requirements as to the number of hours a day and number of days a service can be offered.

Both partial hospitalization and day treatment programs have fallen into disfavor for funding in Ohio. Other states' Medicaid plans continue to allow for funding with specific limitations placed on the types of programming as well a frequency and duration of the service.

Key Factors with the Integration within the Mental Health System

Many factors may be examined to analyze whether or not there is integration within a mental health system. Communication between providers involved in a patient's care is always of importance; especially during the critical stages where the patient is transitioning from one system of care to another. In the context of acute inpatient care, two key factors are readmission rates and post hospital discharge appointments.

Thirty Day Readmission Rates

The readmission rate is the frequency that patients who are discharged from an inpatient facility are re-hospitalized again. A generally accepted national standard of time measurement are thirty and one hundred eighty days following discharge. The NASMHPD Research Institute (NRI) published a sixteen state study of mental health system performance indicators. Quality Indicator No. 12 examined the 30 day and 180 readmission rates as a benchmark indicator.²⁵⁴ The rationale for analyzing readmission rates is that "a major outcome of the development of a community-based

²⁵³ Richard C. Lindrooth, *The Tradeoff between Access to Community Treatment and Acute Hospitalizations of the Severely Mentally Ill*, Medical University of South Carolina, unpublished NIMH-funded study presented at The Ohio State University, December, 2008.

²⁵⁴ Lutterman T, Ganju V, Schacht L, Shaw R, Monihan K, et.al. Sixteen State Study on Mental Health Performance Measures. DHHS Publication No. (SMA) 03-3835. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003, p. 81.

system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds. The goal is to decrease the number of consumers being readmitted to state psychiatric inpatient care within 30/180 days of being discharged.”²⁵⁵

While both the 30 and 180 days time periods are acceptable, whenever both time periods are available the 30 readmission rate is used for this report. Between 30 days and 180 days or beyond, many other independent variables including the patient’s lifestyle, treatment compliance and community supports may come into play that impact on the patient’s ongoing recovery. Within 30 days following discharge there is an increased likelihood that factors under the responsibility of the mental health system may have played a significant role in the patient requiring re-hospitalization. The factors under the control of the mental health system may include: inappropriate discharge due to either the patient’s condition not being improved to where he/she was ready for release and/or poor discharge planning; inadequate or delayed aftercare follow up services including the monitoring of the patient’s medication regimen; or lack of continuity between the inpatient and community based providers.

Private Hospitals’ Readmission Rate for Medicaid Patients

Health Care Excel is a contract agency of the Ohio Department of Mental Health and Job and Family Services. Health Care Excel provides pre-admission approval of Medicaid patients who are referred for admission as well as post-payment retrospective reviews based on red flag indicators determined by the Ohio Department of Mental Health.²⁵⁶ One of the red flag triggers is the readmission of Medicaid patients within thirty days of discharge from the same facility. From 2002 to 2007, the Health Care Excel found a consistent statewide 30 day readmission rate of between 15 and 16 percent.²⁵⁷ In FY 2005, the 30 readmission rate was 15.3 percent. The rate increased to 15.9 percent in FY 2006 and in FY 2007, the readmission rate was 15.8 percent. In FY 2008, the readmission rate declined to 12.9 percent, the lowest rate during the past seven years. The average readmission rate for the past seven years is 15.3 percent. See Figure No. 67 on the following page.

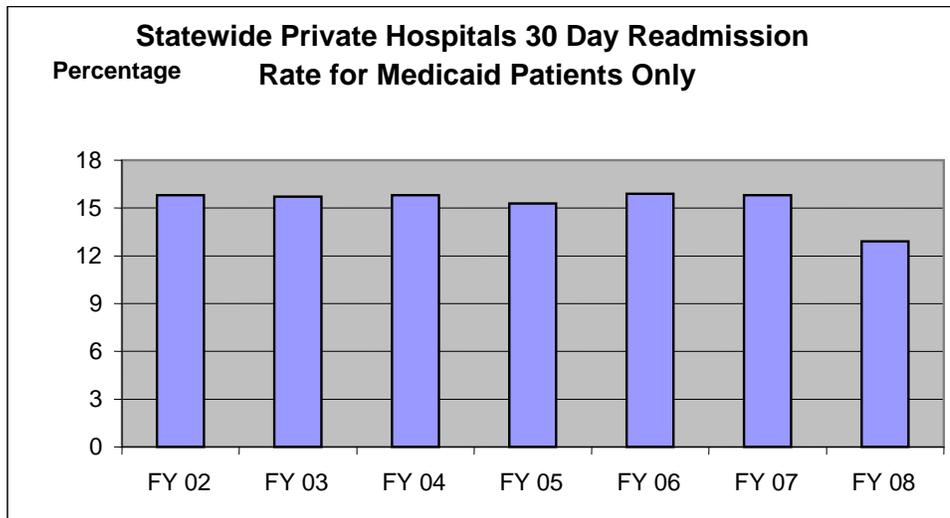
²⁵⁵ *Ibid.*

²⁵⁶ Health Care Excel, *Ohio Utilization Review of Inpatient Psychiatric Care Annual Report- FY 2007*, p. 14. The other red flag indicators for a post-payment retrospective review are: admission of children under nine years of age, outlier payments, length of stay of three days or less, transfers, hospital denial letters, and non-compliance with the pre-admission certification program.

²⁵⁷ *Ibid.*, p. 24.

Figure No. 67.

Private Hospitals Statewide Thirty Day Readmission Rate For Medicaid Patients Only

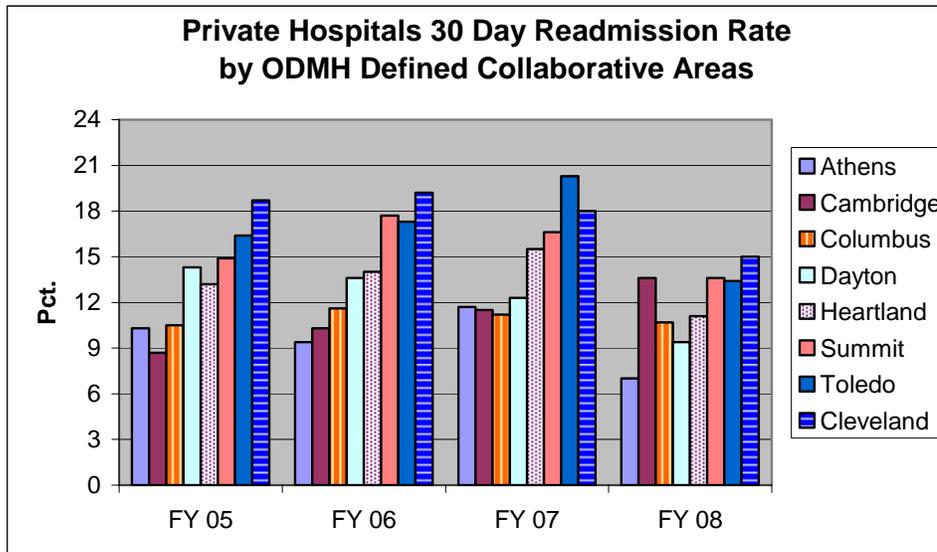


Source: Health Care Excel, 2007 and 2008 Reports

Health Care Excel further broke down the thirty day readmission data for the private psychiatric hospitals into the ODMH defined collaborative areas. For FY 2005 to FY 2008, the Toledo, Cleveland and Summit (Cincinnati area) collaborative areas had the highest readmission rates while the Athens, Cambridge and Columbus collaborative areas had the lowest. The Dayton and Heartland collaboratives were positioned in the middle, but below the average. The decline in the thirty day readmission rate in FY 2008 is encouraging; especially since the decline occurred in all areas of the state, except for the Cambridge area. Hopefully, the FY 2008 experience continues or declines even further. Longitudinal analysis will need to be made to determine if the decline is more than just a one year aberration. See Figure No. 68 on the next page.

Figure No. 68.

Private Hospitals Thirty Day Readmission Rate
by ODMH Defined Collaborative Areas- FY 05 to 08



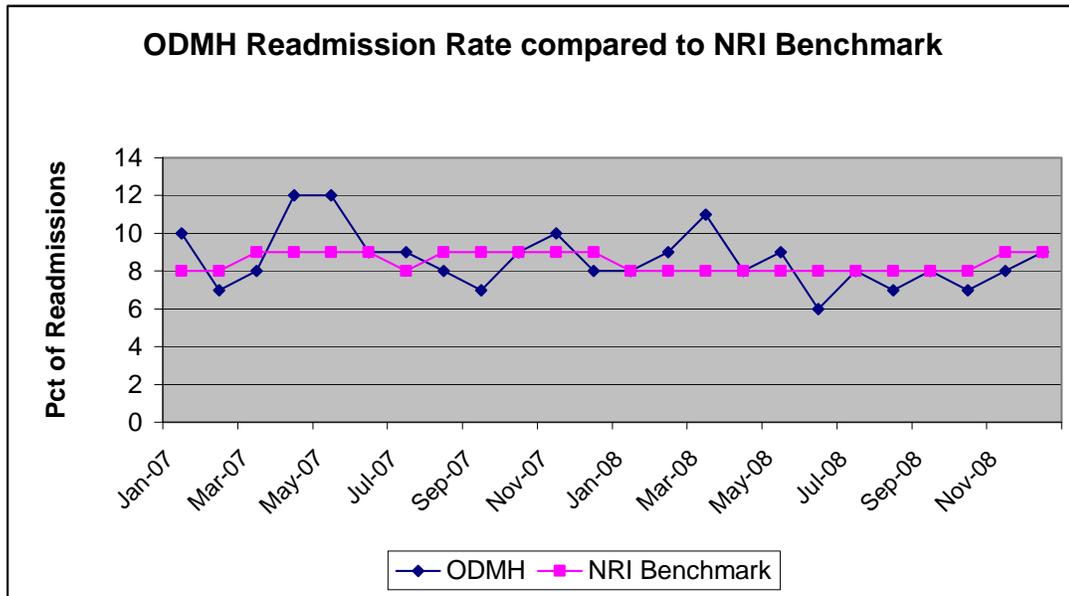
Source: Health Care Excel, 2007 and 2008 Annual Reports

State Hospitals Readmission Rate

The ODMH hospitals have reported an average thirty-day readmission rate from January, 2007 through December, 2008 of nine percent. The percentage is based on 45 patients being readmitted to the same state hospital out of the 516 discharges. During this period the monthly range was a high of 12 percent and a low of six percent. The National NRI Readmission Benchmark Rate during this period was an average of eight percent, with the Benchmark varying between eight and nine percent during this period. During the 24 month period, the ODMH hospitals were below the NRI Benchmark rate for nine months, identical with the benchmark rate for seven months, and above the rate for eight months.²⁵⁸ See Figure No. 69 on the next page.

²⁵⁸ ODMH Patient Care System, *Continuity of Care Priority: 30 Day Readmission Rates to the Same Campus From January 2007 to December 2008 Report*.

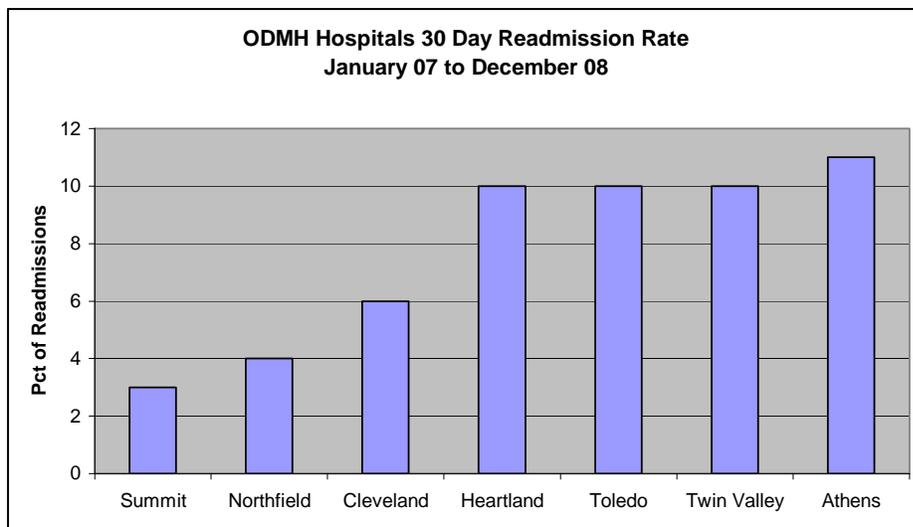
Figure No. 69.



Source: Patient Care System; NRI Readmission Data

During the same 24 month period, the thirty day readmission rates by state hospital ranged from a low of three percent at Heartland to a high of eleven percent at Athens. See Figure No. 70.

Figure No. 70.



Source: Patient Care System

Note: Summit does not normally accept direct admissions from Hamilton Co. which artificially lowers its thirty day readmission rate.

Comparison of Thirty Day Readmission Rate between ODMH State Hospitals and Private Psychiatric Hospitals

Unfortunately, readmission rate data is not consistently maintained across all the inpatient providers. Although the present data gathering efforts can track readmissions to the same private hospital, and in the case of state hospitals, readmission to the same or other state hospital, the ability to track readmissions to another private hospital is not readily available. Given the importance of this data as a measure of the efficiency and effectiveness of a mental health system, effort needs to be made to develop a standardized means to access this information.

With the above caveat, a limited comparison of the thirty day readmission rate between the ODMH state hospitals and the private psychiatric hospitals for the fiscal years, 2002 to 2008 reveals that statewide the private hospitals consistently had a higher thirty day readmission percentage than did the state hospitals. (Note: The private hospital data is for Medicaid patients only.) The difference by year ranged from 4.3 days in FY 2008 to 7.7 days in FY 2004. One explanation for the difference is that the state hospital data includes forensic status discharges that have limited placement options and typically have a low readmission rate. See Table No. 71 and Figure No. 72.

Table No. 71.

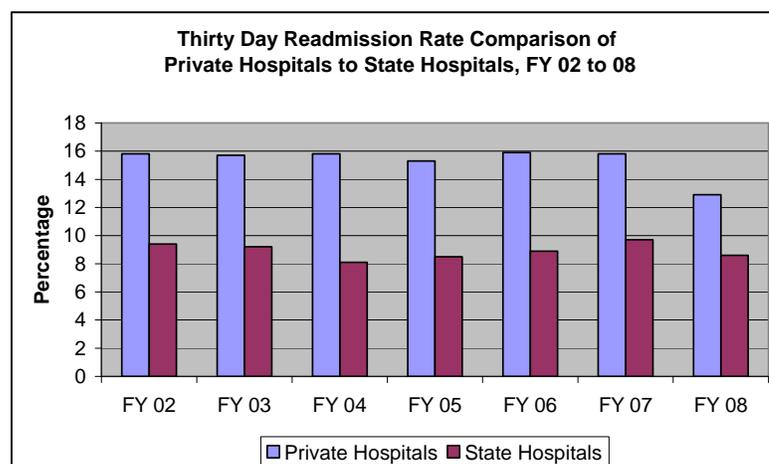
Thirty Day Readmission Percentages (in Days)

	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Private Hospitals	15.8	15.7	15.8	15.3	15.9	15.8	12.9
State Hospitals	9.4	9.2	8.1	8.5	8.9	9.7	8.6
Difference	6.4	6.5	7.7	6.8	7	6.1	4.3

Source: Health Care Excel 2007 and 2008 Annual Reports; ODMH, PCS

Figure No. 72.

Thirty Day Readmission Rate Comparison of Private Hospitals to State Hospitals, FY 02 to 08



Source: Health Care Excel, 2007 and 2008 Annual Reports; ODMH, Patient Care System, Percentage of Readmissions within 30 Days by State Hospital

Breaking down the comparison data further by ODMH defined collaborative areas; we find that the private hospitals in the Columbus collaborative had the lowest 30 day readmission rate in 2007 among the private hospitals at 11.2 percent. The Summit Behavioral Health Care had the lowest 30 day readmission rate among the state hospitals in 2007, as well as the lowest readmission rate overall at 1.8 percent. A possible reason for this outcome is that the Hamilton County ADAMH Board policy requires that patients discharged from Summit Behavioral Health Care who require readmission are to be admitted to a private hospital provider instead of directly back to the state hospital.

The Toledo private hospitals collaborative had the highest 30 day readmission rate among the private hospitals collaborative and overall at 20.4 percent. The Toledo state hospital had the highest 30 day readmission rate among the state hospitals at 15 percent.²⁵⁹

In FY 2008, the Athens private hospital collaborative had the lowest readmission rate among the private hospital collaboratives at seven percent. Summit Behavioral Health Care continued to have the lowest 30 day readmission rate among the state hospitals as well as overall at 3.7 percent. The Cleveland private hospitals collaborative had the highest 30 day readmission rate among the private hospital collaboratives and overall at 15 percent. The Twin Valley Behavioral Health Care, Dayton Campus had the highest readmission rate among the state hospitals at 14.9 percent.²⁶⁰

Looking at each collaborative individually, the Athens collaborative private hospitals and the Appalachian Behavioral Health Care, Athens Campus state hospital have similar 30 day readmission rates. However, in FY 2008, the private hospitals' readmission rate dropped sharply by 40 percent (40.1%), while the state hospital readmission rate declined by only just over nine percent (9.3%).

The Cambridge collaborative also had similar thirty day readmission rates between the private hospitals and the Appalachian Behavioral Health Care, Cambridge Campus state hospital. From FY 2007 to FY 2008, the readmission rate for the private hospitals increased by over 18 percent (18.2%), while the readmission rate for the state hospital declined by slightly over 10 percent (10.2%).

The 30 day readmission rate comparison of the Columbus collaborative private hospitals and the Twin Valley Behavioral Health Care, Columbus Campus were similar; although for both years the readmission rate for the private hospitals in the Columbus collaborative was slightly higher than for the state hospital. From FY 2007 to FY 2008, the Columbus private hospitals collaborative 30 day readmission rate dropped by over four percent (4.4%), while the state hospital readmission rate declined by just under four percent (3.8%).

²⁵⁹ Health Care Excel, 2007 and 2008 *Annual Reports*; ODMH, Patient Care System, *Percentage of Readmissions within 30 Days by State Hospital*.

²⁶⁰ Ibid.

The 30 day readmission rate for the Dayton collaborative private hospitals and the Twin Valley Behavioral Healthy Care, Dayton Campus were similar in FY 2007. However, in FY 2008, the private hospitals' readmission rate dropped moderately by nearly 24 percent (23.5 percent) while the state hospital experienced a similarly sized increase in the readmission rate of just over 24 percent (24.1%).

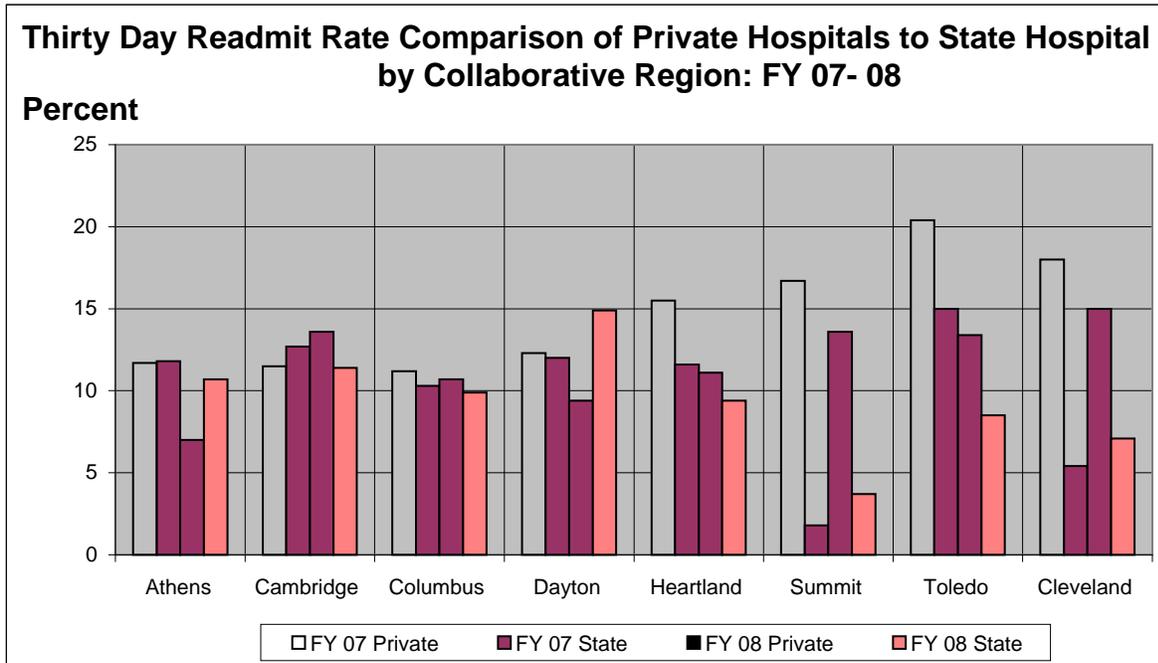
The Heartland collaborative experience over the two years indicates that the readmission rate for both the private hospitals and the Heartland Behavioral Health Care declined moderately from FY 2007 to FY 2008; over 28 percent (28.3%) for the private hospitals and just under 19 percent (18.9%) for the state hospital. However, the state hospitals readmission rate consistently was lower than the private hospitals' readmission rate.

The Summit collaborative reveals the 30 day readmission rate is considerably higher for the private hospitals than for the Summit Behavioral Health Care. Two possible reasons are that the Summit state hospital has a large concentration of forensic status discharges which typically have a low readmission rate due to their more discharge placement options, and that, as noted previously, by Board policy Summit Behavioral Health Care discharged patients are to be readmitted to a private provider. The Summit private hospitals have the third highest readmission rate of all the collaboratives. At the same time, however, the readmission rate dropped slightly from FY 2007 to FY 2008 by over 18 percent (18.5%). The Summit state hospitals readmission rate increased between the two years by over 105 percent (105.5%), but still remained the lowest of all the state hospitals and the collaboratives.

The Toledo collaborative had the highest 30 day readmission rates for FY 2007 for both the private hospitals collaborative and the Northcoast Behavioral Health Care, Toledo Campus of all the collaboratives and state hospitals. In FY 2008, both the private hospitals and the state hospital improved substantially their respective readmission rates; the private hospitals collaborative dropping by over 34 percent (34.3%) and the state hospital readmission rate declining by over 43 percent (43.3%). For both years, the state hospital's readmission rate remained lower than the private hospitals' rate.

The Cleveland collaborative 30 day readmission rate indicates that the private hospitals had a consistently higher readmission rate over both fiscal years than the Northcoast Behavioral Health Care, Cleveland Campus. For FY 2008, the Cleveland collaborative private hospitals had the highest readmission rate of all the collaboratives. At the same time, from FY 2007 to FY 2008 the readmission rate improved slightly for the private hospitals by over 16 percent (16.6%), and worsened moderately for the state hospital by over 31 percent (31.4%). The Northcoast Behavioral Health Care, Northfield Campus was not included in the state hospitals comparison due to the low number of discharges from that campus. If the Northfield Campus had been included, the result for the combined state hospitals would have been even lower because the Northfield Campus provides care for patients considered to need a longer term of inpatient treatment. See Figure No. 73.

Figure No. 73.



Source: Health Care Excel for Private Hospital Information; Patient Care System for State Hospital Information
 Note: Cleveland state hospital data only includes the Cleveland Campus. The Northfield Campus is not included due to low discharge rate in FY 08.

Post-Discharge Appointments within Fourteen Days

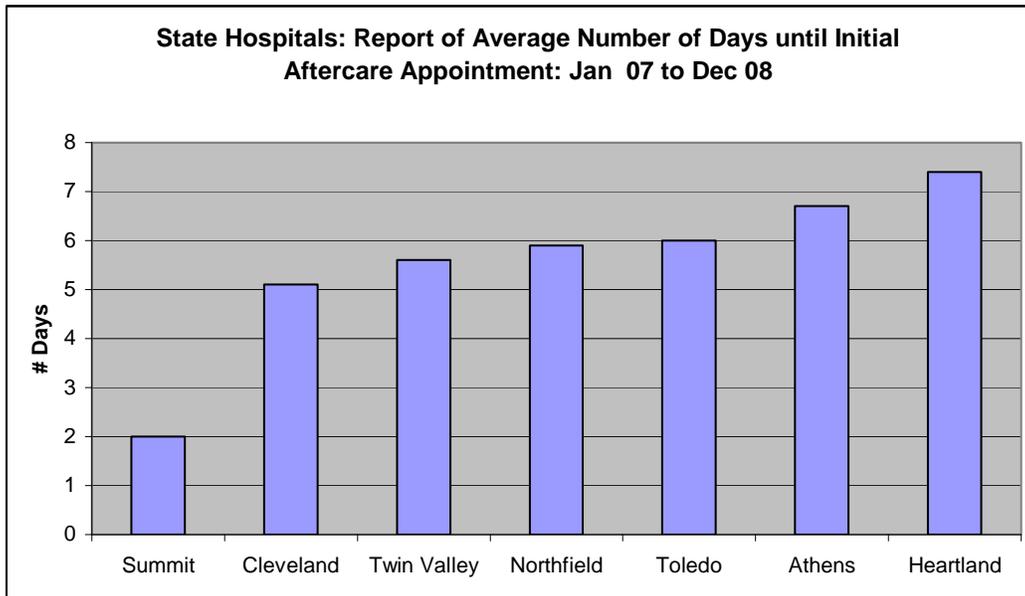
Another key indicator of the status of the Integration within the Mental Health System is the compliance percentage with the Ohio Administrative Code requirement of a post-discharge appointment within fourteen days of the patient's discharge. For the 24 month time period from January, 2007 to December, 2008, the ODMH average was a compliance rate of 89 percent. The monthly compliance percentages ranged from 83 to 93 percent. The average number of days to the initial aftercare appointment was just under six days (5.9).²⁶¹

A comparison of the state hospitals by the post-discharge appointment indicator reveals that all of the hospitals' performance was around the ninety percent compliance rate. The lowest compliance rate was at Heartland with 86 percent and the highest

²⁶¹ ODMH Patient Care System, *Continuity of Care Priority: Percentage of Discharges with Appointments Within 14 Days From January 2007 to December 2008 Report*.

compliance rate was reported by Twin Valley at 96 percent.²⁶² The average number of days before the first aftercare appointment following discharge ranged from two days at Summit to over seven (7.4) days at Heartland. See Figure No. 74.

Figure No. 74.



Source: ODMH, Patient Care System

Daily Psychiatric Bed Monitoring Across Inpatient Providers

An innovative approach to address a chronically tight psychiatric bed situation is underway in Franklin County. On a daily basis, a morning conference call is conducted involving key personnel from each of the private psychiatric hospitals in the county, Netcare Access, and Twin Valley Behavioral Healthcare. The main topics of discussion are: a review of the available beds at each hospital, the anticipated beds that may become available during the day, as well as the potential admissions from Netcare Access. The intersystem collaborative approach has helped increase the cooperation and communication among all the parties to proactively meet the demand for inpatient beds in the county.

An improvement to the daily conference call procedure is the development of a computerized tracking database with pull down menus. The database allows the above parties to track the bed availability in real time throughout the Franklin County inpatient system. The password protected database keeps track of each hospital's:

- bed capacity;
- current census;

²⁶² Ibid.

- number of potential admissions to the psychiatric unit who are either in the emergency department or in a medical/surgical bed;
- payer status and gender of each potential patient;
- number of beds currently available; and
- the number of potential discharges during the day.

Each hospital assigns key personnel to maintain a current database and to insure that accurate and timely information is available to assist all parties in making informed decisions.

Children and Adolescent Acute Care Treatment

The provision of, and ready access to, comprehensive services for children and adolescents is a critical component of the community's overall acute care treatment regimen. In advocacy for this vulnerable population, the National Association of Psychiatric Health Systems (NAPHS) published in March, 2006 a joint communiqué with the National Association for Children's Behavioral Health (NACBH), entitled, *Medicaid: Principles for Treatment of Children and Youth with Emotional and Substance Abuse Disorders*. The two national groups recommended the following principles for the U.S. Congress and states:

- 1) Emotional health is essential to overall health;
- 2) Short and long term improved health can result from early, appropriate, and adequate intervention and treatment;
- 3) The needs of the child must drive treatment and placement;
- 4) A comprehensive evaluation is the appropriate entry point for determining care and treatment needs;
- 5) The child and the family (or guardians) are partners in developing and implementing a family-centered treatment plan;
- 6) Children and youth with behavioral disorders must have 24-hour access to comprehensive array of behavioral health services. The array of services included psychiatric hospitalization as well as emergency and outpatient services.
- 7) Every child needs a safe treatment environment
- 8) Services need to be coordinated across multiple and overlapping systems;
- 9) Funding and payment must be commensurate with the cost of providing the fully array of services.²⁶³

To support these principles, the communiqué stated that the U.S. Congress and the states should:

²⁶³ National Association for Children's Mental Health, *Medicaid: Principles for Treatment of Children and Youth with Emotional and Substance Abuse Disorders*, March, 2006, p. 2.

- 1) Ensure a comprehensive evaluation and screening is done for every child. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program was identified. (Note: According to the U.S. Health Resources and Services Administration, EPSDT is the “child health component of Medicaid. It’s required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.”)²⁶⁴
- 2) Protect the coordination of the services through targeted case management.
- 3) Protect rehabilitation and clinic options as available to receive Medicaid payment.
- 4) Provide accountability to ensure quality and safety of children who are “most at risk and most in need” of receiving the 24-hour behavioral services.²⁶⁵

The readmission rates for children and adolescents who have been discharged from an acute care psychiatric facility lends insights into the effectiveness of the mental health assessment and treatment services provided to these two age groups.

Health Care Excel identified in their 2007 Annual Report that the readmission rate within 180 days of discharge for children up to nine years of age was 28 percent. For pre-teens, adolescents and young adults from the ages of 10 to 21, the readmission rate was 47 percent, just one percent lower than the readmission rate for adults ages 22 to 64.²⁶⁶ The 180 day readmission rate for all patients was 47 percent.

In FY 2008, the overall readmission rate declined from 47 percent to 34 percent. By age group, the readmission rate for children up to nine years of age increased to 29 percent. The readmission rate for pre-teens, adolescents and young adults from the ages of 10 to 21, dropped slightly to 41 percent. The readmission rate for this age group was the highest of any age category, eclipsing the rate for adults ages 22 to 64 that dropped substantially from 48 percent to 30 percent. As with the 30 day readmission data by collaborative, the 180 day readmission rate data by age group reveals a significant decline for the adult age group. However, unlike the readmission rates among adults, the 10 to 21 age group only declined slightly and the readmission rate for children did not decline at all, but rather increased slightly.²⁶⁷ See Figure No. 75 on the following page.

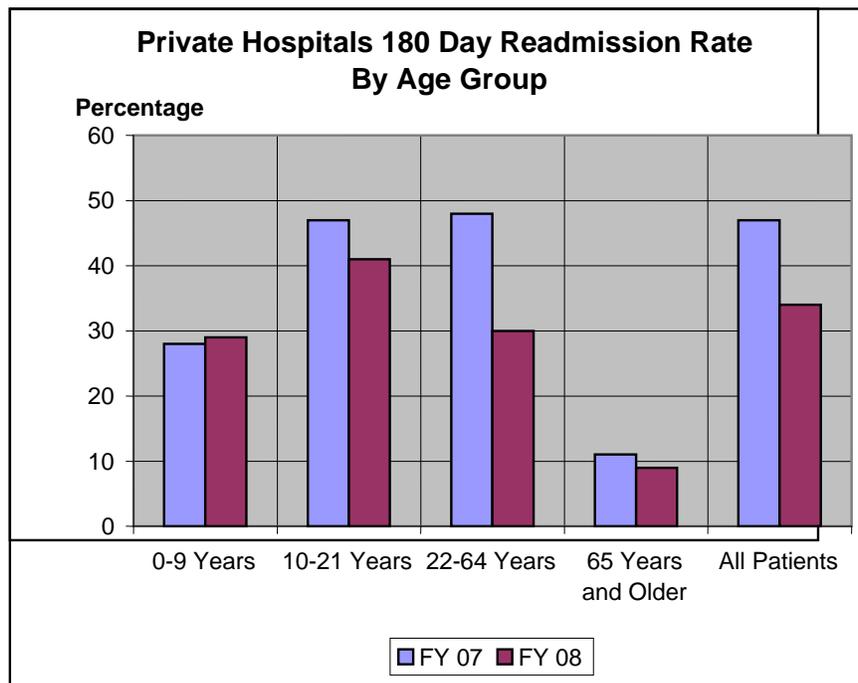
²⁶⁴ Health Resources and Services Administration, *EPSDT and Title V Collaboration to Improve Child Health*, www.hrsa.gov/epsdt.

²⁶⁵ National Association for Children’s Mental Health, *Medicaid: Principles for Treatment of Children and Youth with Emotional and Substance Abuse Disorders*, March, 2006, p. 3.

²⁶⁶ Health Care Excel 2007 Annual Report, p. 29.

²⁶⁷ Health Care Excel, 2008 Annual Report, p. 27.

Figure No. 75.



Source: Health Care Excel, 2007 and 2008 Annual Reports

By Diagnostic Related Group, the readmission rate within one hundred eighty days for Childhood Mental Disorders was 32 percent in FY 2007 and dropped to 30 percent in FY 2008.²⁶⁸ While it is recognized that many variables can come into play six months following discharge, these high readmission rates for children and adolescents denote a potential problem in the inpatient and outpatient treatment programming and linkage presently in place for these vulnerable populations. Further study is needed, including the compilation and evaluation of 30 day readmission data. But these readmission findings point to the need to reexamine the foundation of inpatient care for children and adolescents.

Impact of Adverse Childhood Experiences

Especially troubling are issues of emotional, physical, and sexual trauma and its immediate effects on children and latent impact on adults. The U.S. Centers for Disease Control (CDC) Adverse Childhood Experiences (ACE) Study well documents the mental, emotional and physical maladies that are directly related to adverse childhood experiences.²⁶⁹ The eight categories of adverse childhood experiences included:

²⁶⁸ Health Care Excel, 2007 Report, p. 30; Health Care Excel, 2008 Annual Report, p. 28.

²⁶⁹ Vincent J. Felitti, "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead", *Z psychosom Med Psychother* 2002; 48(4): 359-369; National Center for Disease Control and Prevention. *ACE Study: Adverse Childhood Experiences Study*, www.cdc.gov/nccdphp/ACE.

recurrent physical abuse; recurrent emotional abuse; sexual abuse; growing up in a household where someone was in prison; where the mother was treated violently; growing up with an alcoholic or drug user; where someone was chronically depressed, mentally ill or suicidal; and where at least one biological parent was lost to the patient during childhood.²⁷⁰ Some of the key findings of the ACE study were the strong link between adverse childhood experiences and smoking and chronic obstructive pulmonary disease, intravenous drug use, attempted suicide, and morbid obesity.²⁷¹ In short, as Dr. Vincent Felitti phrased it, “this reverse alchemy, turning the gold of a newborn infant into the lead of a depressed, diseased adult.”²⁷² Several studies found that between 34 percent and 53 percent of persons with a severe mental illness reported a history of childhood physical/sexual abuse.²⁷³

A recent study found that post traumatic stress disorder (PTSD) is a common “but under diagnosed disorder among adolescents with severe emotional and behavioral disorders who are involved in multiple service systems.”²⁷⁴ The researchers determined that “the rate of current PTSD was 28 percent, which was under diagnosed in adolescents’ medical records.” They found that PTSD was more prevalent among girls, those with a history of sexual abuse, those with a diagnosis of depression in the medical record, and those treated by multiple psychotropic medications. The researchers also found that adolescents with PTSD “were more likely to have run away, engaged in self-injurious and delinquent behavior, reported higher anxiety and depressions, and functioned worse at school and home than those without PTSD.”²⁷⁵ The researchers recommended that “routine screening for trauma exposure and PTSD should be conducted with all adolescents receiving mental health services so that treatment can be provided to those with PTSD.”²⁷⁶

Another study found that among psychiatrically hospitalized adolescents using two self-report data collection instruments, “consistent reports of physical and sexual abuse were given by 86 percent and 71 percent respectively.” The researchers further found that the patients “were significantly more depressed and suicidal and reported higher levels of sexual abuse and emotional and physical neglect.”²⁷⁷

²⁷⁰ *Ibid.*

²⁷¹ *Ibid.*

²⁷² Felitti, Vincent J. “The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead”, *Z psychsom Med Psychother* 2002; 48(4): 359-369.

²⁷³ Missouri Institute of Mental Health, “Trauma among People with Mental Illness and/or Substance Use Disorders”, *Fact Sheet*, University of Missouri-Columbia, School of Medicine, November 2002, p. 1.

²⁷⁴ Kim Mueser and Jonas Taub, “Trauma and PTSD among Adolescents with Severe Emotional Disorders Involved in Multiple Service System,” *Psychiatric Services*, 59:627-634, June, 2008.

²⁷⁵ *Ibid.*

²⁷⁶ *Ibid.*

²⁷⁷ Deborah Lipschitz, et. al., “Hospitalized adolescents' reports of sexual and physical abuse: A comparison of two self-report measures,” *Journal of Traumatic Stress*, Volume 12 Issue 4, 641 – 654, June 30, 2005.

The awareness of the impact of adverse childhood experiences, including trauma and PTSD is growing among mental health professionals as well as the general public. What is needed is a concerted effort to translate this awareness into concrete assessment and treatment protocols within acute care inpatient services. Inpatient providers are in a unique position to assess and initiate treatment and outpatient referral to help children and adolescents suffering from the effects of adverse childhood experiences.

However, all too often the focus is on behavioral amelioration rather than on the underlying causes of the problematic acting out. The early intervention of effective treatment modalities is crucial to reduce the long range impact. There exist effective treatment modalities to address the effects of trauma in children and adolescents. A few examples of effective treatment models or programs are: the *Sanctuary Model*²⁷⁸, *Seeking Safety Model*²⁷⁹, *Trauma Focused Cognitive Behavioral Therapy*²⁸⁰, *Real Life Heroes*,²⁸¹ *Trauma Recognized Empowerment for Adolescent Girls and Young Women, Age 12-18: A Clinician's Guide for Working with Adolescent Girls in Groups*,²⁸² *Triad Girls Group Treatment Model*,²⁸³ and *Voices: A Program of Self-Discovery and Empowerment for Girls*.²⁸⁴

The treatment modality, Eye Movement Desensitization and Reprocessing (EMDR) has also been demonstrated to be a promising technique to treat children and adolescents who suffer from trauma and loss. Researchers into this modality note that studies with children and adolescents are comparable to adult studies, and that "it is likely that EMDR will prove to be about as effective with children and adolescents as with adults. Over the past decade or so, many more studies have been conducted regarding the efficacy of EMDR with children and adolescents."²⁸⁵ EMDR is generally considered "as a first line treatment for children and adolescents suffering from the effects of trauma. It

²⁷⁸ Ann Jennings, "Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services", prepared for NASMHPD and SAMHSA, 2004, p. 48-49.

²⁷⁹ *Ibid.*, p. 50.

²⁸⁰ *Ibid.*, p. 51.

²⁸¹ *Ibid.*, p. 48.

²⁸² *Ibid.*, p. 51

²⁸³ *Ibid.*, p. 53.

²⁸⁴ *Ibid.*

²⁸⁵ A few EMDR studies are cited: Robbie L. Adler-Tapia, & Settle, C.S. EMDR in the treatment of childhood depression: Findings from a pilot study. Paper presented at the 23rd Annual San Diego International Conference on Child & Family Maltreatment, 2009; A. Ahmad, et. al. "EMDR treatment for children with PTSD: Results of a randomized controlled trial". *Nordic Journal of Psychiatry*, 61(5), 349-354, 2007; G. Soberman, et. al. "A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems". *Journal of Aggression, Maltreatment and Trauma*, 6 (1), 217-236, 2002; G. Tufnell, "Eye movement desensitization and reprocessing in the treatment of pre-adolescent children with post-traumatic symptoms." *Clinical Child Psychology and Psychiatry*, 10 (4), 587-600, 2005.

should be clearly understood that EMDR is not a stand-alone technique, but a tool judiciously used by a qualified clinician in the context of an overall treatment plan.”²⁸⁶

The President’s New Freedom Commission on Mental Health Final Report espoused the need for greater system integration and the development of a Public Health Model to address trauma and its impact. Among the recommendations of the President’s New Freedom Commission were:

- Workforce orientation, training, support, competencies and job standards related to trauma;
- Linkages with higher education to promote education of professionals in Trauma;
- Consumer/Trauma Survivor/Recovering person involvement and trauma informed rights;
- Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status;
- Systems integration/coordination between and among systems of care serving persons with trauma histories, and including life-span perspective;
- Financing criteria and mechanisms to pay for best practice trauma treatment models and services;
- Clinical practice guidelines for working with people with trauma histories;
- Procedures to avoid retraumatization and reduce impacts of trauma, including:

“...practices such as seclusion and restraint, involuntary medication, etc. Training should cover dynamics of retraumatization and how some practices could mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Specific policies should be in place to create safety; acknowledge and minimize the potential for retraumatization; assess trauma history; address trauma history in treatment and discharge plans; respect gender differences; and provide immediate intervention to mitigate effects should interpersonal violence occur in care settings.”²⁸⁷

- Rules, regulations and standards to support access to evidence-based and emerging best practices in trauma treatment;
- Trauma screening and assessment;
- Trauma-informed services and service systems, and
- Trauma-specific services, including evidence-based and emerging best practice treatment models.²⁸⁸

The integration of these recommendations and effective treatment models into the acute care inpatient services is a key need.

²⁸⁶ Ricky Greenwald, “Eye Movement Desensitization and Reprocessing (EMDR): New Hope for Children Suffering from Trauma and Loss,” *Clinical Child Psychology and Psychiatry*, 3, 279-287, 1998.

²⁸⁷ *Ibid.*, p. 67.

²⁸⁸ *Ibid.*, pp. 65-69.

Part VI Measures of Service Integration within the Mental Health System Key Points

- 1) The mental health system continues to be under stress with the demand for more services while funding for services cannot keep up with the demand.
- 2) One of the most critical times in providing a client with mental health services is during the 'hand-off' between outpatient and inpatient treatment or vice versa, as well as between multiple outpatient treatment providers. Readmission rates can be a measure of how effective a system is operating in assuring that clients do not 'fall between the cracks' of the various provider systems.
- 3) Unfortunately, readmission rate data is not consistently maintained across all the inpatient providers. Though the present data gathering efforts can track readmissions to the same private hospital and in the case of state hospitals, readmission to the same or other state hospital, the ability to track readmissions to another private hospital is not readily available. Given the importance of this data as a measure of the efficiency and effectiveness of a mental health system, effort needs to be made to develop a standardized means to access this information.
- 4) The use of partial hospitalization programs continues to decline due to the service being in disfavor by many insurance companies and managed care entities. A recent national study may provide support for the potential value of these programs in reducing the number of inpatient admissions.
- 5) The ODMH state hospitals readmission rate is generally closely in line with the national data. There are four hospitals with rates above the national average during the 24 month study period.
- 6) The available data from the Patient Care System indicates that the mental health agencies in Ohio are consistently in compliance with the 14 day standard for the initial aftercare appointment following discharge from a state hospital.
- 7) The daily conference call regarding bed availability in Franklin County is an example of intersystem cooperation to address an ongoing system-wide problem. The project has furthered cooperation, communication and understanding among all the parties involved in addressing the tight bed situation. The project has also evolved into the development of a computerized tracking system to allow all parties to evaluate bed availability and need in real time.
- 8) Children and adolescent assessment and treatment are critical components of an acute care mental health system. The available readmission data points to problems in the effectiveness of the programs for these two vulnerable age groups. Further evaluation is needed. Additionally, the issue of trauma is gaining greater awareness as

a significant problem; the effects of which can be debilitating for an extended period time if not properly assessed and treated.

Part VII

Integration with Physical Health

Part VII

Integration with Physical Health

The need to integrate mental health and physical health services is gaining greater appreciation and attention. The Bazelon Center for Mental Health Law noted, “Numerous studies over the past 30 years have found high rates of physical health-related problems and death among individuals with serious mental illnesses.”²⁸⁹ The Bazelon Center cited a Massachusetts study that discovered that “adults with a mental illness were roughly twice as likely to have multiple medical disorders as adults without a mental illness.”²⁹⁰ Persons who had concomitantly both a mental illness and substance abuse disorder were the most likely to suffer from multiple medical problems. The study further noted that “as many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure.”²⁹¹ Persons with severe mental illnesses were also found to have higher rates of HIV/AIDS than the general population.²⁹²

A study that looked at the death rates among persons with mental illness in eight states from 1976 to 1985 determined that 60 percent were the result of cardiovascular, metabolic and infectious diseases that were preventable and treatable.²⁹³ For example, a study in Maine of Medicaid recipients found that persons with serious mental illnesses had “significantly higher prevalence of major medical conditions that are in large part preventable, including diabetes, metabolic syndrome, lung and liver diseases, hypertension, cardiovascular disease, infectious diseases, and dental disorders.”²⁹⁴

The Maine study found that seventy percent of the persons with mental illness had at least one chronic health condition, and nearly thirty percent had three more chronic

²⁸⁹ Elaine Alfano, *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders, Executive Summary*, Washington, D.C.: Bazelon Center for Mental Health Law, June, 2004, p. 1.

²⁹⁰ *Ibid.*

²⁹¹ *Ibid.*

²⁹² Marcela Hortvitz-Lennon, et. al. “From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses,” *Health Affairs*, 25, No. 3, 659:669, 2006.

²⁹³ Health Foundation of Greater Cincinnati, “Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses,” *Location, Location, Location: Providing Physical Health Care in Other Settings to Increase Access*, Issue 1, October, 2008, p. 1.

²⁹⁴ Joseph Parks, et. al., *Measurement of Health Status for People with Serious Mental Illnesses*, Alexandria, Va.: National Association of State Mental Health Program Directors, October 16, 2008, p. 5.

medical conditions.²⁹⁵ A separate study conducted in Massachusetts found similar results. The Massachusetts study further noted that chronic pulmonary illness was the most prevalent co-morbid disease impacting on thirty-one percent of those persons included in the study.²⁹⁶

Oral health is another area that is of growing concern for persons with a serious mental illness. Many of the psychotropic medications “cause dry mouth and lead to dry tooth destruction...over 700 prescription medications decrease saliva flow. These include: anti-psychotics, antihistamines, antidepressants, anticholinergics, mood stabilizers, etc. Adequate salivary flow and its unique composition of proteins are essential to the maintenance of oral tissues,²⁹⁷ dental hygienist Lisa Knapp noted. She further recommended that “dental professionals need to be directly involved with the consumers concerning oral health to ensure total care. Mental health professionals and caregivers need to include and monitor oral health as part of the patients overall health assessment.”²⁹⁸

An ODMH study examined the medical co-morbidity and early deaths among persons with serious mental illness. The study examined patients who were discharged from Ohio’s state hospitals from 1991 to 2002 and who passed away within this same time period. The study found that the leading cause of death was heart disease (21 percent) followed by suicide (18 percent), accidents (14 percent) and malignant neoplasms (7 percent).²⁹⁹ The Ohio study looked at the years of potential life lost (YPLL) and found that the overall average was 32 years lost due to early death.³⁰⁰ The mean age of death was 47.7 years.³⁰¹ Obesity and hypertension were the most common medical co-morbid conditions among the population in the study. The Ohio researchers found that “observed deaths in our patient population were more than three times as high as expected, compared with the U.S. general population.”³⁰²

Several factors are suggested as underlying the high prevalence of serious co-morbid medical disorders in persons with mental illness. These factors include: “medication-induced weight gain, poor personal hygiene, reduced physical activity, the increased prevalence of smoking, increased substance use, and inadequate social support systems all are likely to contribute to the development of hypertension, diabetes mellitus, infections, COPD [chronic obstructive pulmonary disease], heart disease, and

²⁹⁵ Elsie Freeman, et. al., “The Poor Health Status of Consumers of Mental Healthcare: Behavioral Disorders and Chronic Disease,” paper presented to NASMHPD Medical Directors Work Group, May, 2006.

²⁹⁶ Danson R. Jones, et. al., “Prevalence, Severity, and Co-occurrence of Chronic Physical Health Problems of Persons with Serious Mental Illness,” *Psychiatric Services*, Vol. 55, No. 11, November, 2004, p. 1250.

²⁹⁷ Lisa Knapp, RDH, “Medication, Devastation, Tooth Preservation: A Call for Action,” NAMI Voice, No. 15, October, 2008, p. 4.

²⁹⁸ *Ibid.*

²⁹⁹ Brian Miller, et. al., “Mortality and Medical Comorbidity among Patients with Serious Mental Illness,” *Psychiatric Services*, Vol. 57, No. 10, October, 2002, p. 1482.

³⁰⁰ *Ibid.*

³⁰¹ *Ibid.*

³⁰² *Ibid.*

injuries.³⁰³ A recent study found that persons with mental illnesses were “66-75% more likely to use tobacco than people who do not have mental illnesses.”³⁰⁴

Additionally, persons with severe mental illness were the victims of violent crime four times higher than the general population rates. A study completed in 2005 found that over one-fourth of persons with severe mental illness (25.3 percent) were victims of a violent crime in the previous year, which was eleven times higher than the general population.³⁰⁵ Persons with severe mental illness had a prevalence rate that was 22.5 times higher in the case of the crime of rape, 7.9 times higher for robbery, and 13.1 times higher for aggravated assault. Persons with severe mental illness had a prevalence rate that was 15.5 times higher for being threatened with a weapon than the general population.³⁰⁶ The researchers concluded that “Crime victimization is a major public health problem among persons with SMI [severe mentally illness] who are treated in the community.”³⁰⁷ The impact on a person’s mental condition as a result of being a victim of a violent crime is profound; equally profound may be the impact on the person’s overall physical health especially if the victim is reluctant to seek prompt medical attention.

In order to address this serious and growing physical health problem among persons with serious mental illnesses, several studies have pointed to the need for greater integration of physical health considerations in the overall treatment and care plan of persons with severe mental illnesses. A key consideration is access to comprehensive physical health services.

Several barriers are cited as preventing persons with serious mental illnesses from seeking out and receiving comprehensive medical care. These barriers can be grouped into four major categories: individual, provider, system, and the impact of stigma. Among the individual factors are the symptoms of depression, fearfulness and social isolation that may “interfere with recognizing physical symptoms or with seeking help for physical problems.”³⁰⁸

At the provider level, the need for clinical integration or holistic care is the desired state. Holistic care would be evidenced by improved communication among all providers, collaboration in treatment planning and interventions, comprehensive care that addresses all aspects of a person’s health needs, and consistent continuity of care. A useful analogy of the current discontinuity is that of the mental health field and the

³⁰³ *Ibid.*, p. 1486.

³⁰⁴ Health Foundation of Greater Cincinnati, “Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses,” *Location, Location, Location: Providing Physical Health Care in Other Settings to Increase Access*, Issue 1, October, 2008, p. 2.

³⁰⁵ Linda Teplin, et. al., “Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey,” *Archives of General Psychiatry*, Vol. 62, August, 2005, p. 914.

³⁰⁶ *Ibid.*

³⁰⁷ *Ibid.*, p. 917.

³⁰⁸ *Ibid.*

physical health field isolated in distinct and separate silos,³⁰⁹ constrained by a “different practice style, vocabulary, and culture that can make communication difficult.”³¹⁰ For mental health professionals, “insufficient attention [is] paid by all disciplines to developing and sustaining the skills necessary for interdisciplinary practice at the professional, post graduate, and continuing education stages [that] render mental health professionals ill prepared to deliver clinically integrated care.”³¹¹ For general practitioners, “it is noteworthy that expectations for mental health competencies among general practitioners are also inconsistent with the provision of high-quality care of people with severe mental illnesses.”³¹² Additionally, “a long history of separation has left providers unfamiliar with issues in the other’s field. While psychiatrists may discount primary care physician’s knowledge of mental health issues, primary care physicians often see psychiatrists as inaccessible, non-medical and uncommunicative...Difference in professional style impede close working relationships. Primary care physicians often experience frustration in attempts to work with mental health providers, particularly with public mental health programs, because they are unaccustomed to working with agencies and interdisciplinary teams. They may become discouraged if they cannot reach a psychiatrist and are expected to discuss a case with another mental health professional or case manager.”³¹³ In addition, “primary care providers are reluctant to refer patients if there are long waiting lists for services and if they have been unable in the past to secure mental health specialty services for their patients...Access to primary care is also an issue. Studies consistently show that people with mental disorders are less likely to be treated for physical conditions and less likely to receive preventative care.”³¹⁴

Information technology and the exchange of information between mental health providers and physical health providers remain problematic. “Most people with severe mental illnesses are cared for in practices whose information systems are underdeveloped or poorly integrated with general health practices...Information exchange is also constrained by a complicated array of privacy rules and overzealous attitude by mental health providers.”³¹⁵ State laws and practitioners practices can be more restrictive of the flow of information than even required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996.³¹⁶

³⁰⁹ Marcela Hortvitz-Lennon, et. al. “From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses,” *Health Affairs*, 25, No. 3, 659:669, 2006.

³¹⁰ Health Foundation of Greater Cincinnati, “Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses,” *Location, Location, Location: Providing Physical Health Care in Other Settings to Increase Access*, Issue 1, October, 2008, p. 3.

³¹¹ Marcela Hortvitz-Lennon, p. 660.

³¹² *Ibid.*

³¹³ Elaine Alfano, *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders, Executive Summary*, Washington, D.C.: Bazelon Center for Mental Health Law, June, 2004, p. 3.

³¹⁴ *Ibid.*, p. 3-4.

³¹⁵ Marcela Hortvitz-Lennon, p. 60.

³¹⁶ *Ibid.*

As an introductory step to promote continuity of care and facilitate communication between mental health and physical health providers, “ODMH felt it was critical that Ohio law be brought in line with HIPAA and broadened to permit exchange of mental health records between community mental health care providers and other health care providers.”³¹⁷

Language was inserted into § 5122.31 (7) of the Ohio Revised Code which reads: “That hospitals within the department, other institutions and facilities within the department, and community mental health agencies may exchange psychiatric records and other pertinent information with other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for a patient.”³¹⁸ The revised law was effective on October 16, 2009.

As a result, the Institute of Medicine found that the U.S. health care system is “a highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities.”³¹⁹ The lack of communication and collaboration results in a health care system that “remains poorly interconnected, and the care to be provided to the 125 million chronically ill Americans remains poorly integrated.”³²⁰

A national survey of community mental health centers conducted in 2008 found that while most community mental health centers acknowledged having the capacity “to screen for common medical conditions, they reported a variety of barriers to providing medical care for those problems either on site or via referral.”³²¹ The barriers included issues with reimbursement, physical plant limitations, lack of referral options, and work force constraints. Less than one-third of the CMHCs responding could provide basic medical services on location.

At the system level, “the current U.S. healthcare system separates treatment for physical and mental illnesses. The physical and mental health care systems have different treatment guidelines, payment rates, rules, and provider qualifications and specialties. Each system is used to providing a specific set of services and referring people to other systems for services outside of what they provide. Typically, the systems do not talk to each other about treatment practices or how they refer patients.”³²²

³¹⁷ Director Sandra Stephenson, “Amendment to Ohio’s Statute Governing Exchange of Psychiatric Treatment Information in the Publicly Funded Mental Health System,” October 13, 2009.

³¹⁸ Ohio Revised Code § 5122.31, paragraph 7, effective October 16, 2009.

³¹⁹ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century*, Washington, D.C.: National Academies Press, 3, 2001, 111:144.

³²⁰ Marcela Hortvitz-Lennon, et. al. “From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses,” *Health Affairs*, 25, No. 3, 659:669, 2006.

³²¹ Benjamin G. Druss, et. al., “Medical Services for Clients in Community Mental Health Centers: Results From a National Survey,” *Psychiatric Services*, vol. 59, 917-920, August, 2008.

³²² Health Foundation of Greater Cincinnati, “Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Health Disparities for People with Severe Mental Illnesses,” *Location, Location, Location*, No. 1, October, 2008, p. 3.

Another key systemic barrier is the different payment structures for services rendered by the mental health and physical healthcare systems. “Insurance benefits for mental health services are typically more restricted and more heavily managed than benefits for physical health services. Insurance plans may not cover physical health screening, care management, and other preventive services if they happen in a mental health treatment provider’s office.”³²³

Finally, stigma continues to be a significant barrier. Persons suffering with serious mental illnesses face stigma on nearly a daily basis, either through direct social interactions with others or indirectly through the media and entertainment venues. Among the consequences of stigma are “lowered self-esteem, loss of confidence, and in some cases, an increase in anxiety and depression.”³²⁴ Stigma can also be associated with non-compliance with medication treatment, and can also interfere with the establishment of the therapeutic relationship with treatment providers. “If people with mental illnesses experience stigma from a healthcare provider, they become less likely to seek healthcare, less likely to disclose health concerns, and less trustful of healthcare providers in the future.”³²⁵ The stigma from healthcare providers can take the form of being treated with disrespect or impatience or of disbelieving the individual’s physical complaints and discouraging them from setting their hopes of recovery too high.³²⁶

Over the past couple of years, a concerted effort has been made across the country and in Ohio to achieve greater integration of physical health services with mental health services. The National Association of State Mental Health Program Directors published a report in October, 2008 entitled, *Measurement of Health Status for People with Serious Mental Illnesses*. The two guiding principles set forth in the report were:

- 1) Mental health is essential to overall health and vice versa;
- 2) Recovery includes wellness.³²⁷

Acknowledging that the report represented only an initial step, the NASMHPD indicated the vision is to achieve “Integrated Healthcare in the Mental Health System for People with Serious Mental Illnesses.”³²⁸ The report noted that the focus will be “on creating systematic capacity to measure baseline data and the future impact of our initiatives...also included in this measurement capacity is the adoption of proven population surveillance tools currently in use within the field of public health and the application of these tools to mental health surveillance (e.g., including standard health status questions within SMHA consumer-oriented surveys).”³²⁹ The concluding statement of the foreword of the report noted, “We must prioritize and bring urgency to

³²³ Ibid., p. 4.

³²⁴ Ibid.

³²⁵ Ibid.

³²⁶ Ibid.

³²⁷ Joseph Parks, et. al., *Measurement of Health Status for People with Serious Mental Illnesses*, Alexandria, Va.: National Association of State Mental Health Program Directors, October 16, 2008, p. 1.

³²⁸ Ibid.

³²⁹ Ibid.

our work in order to fight this epidemic of premature death and its contributing causes.”
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The NASMHPD Report pledged to reduce early mortality of persons with serious mental illness “10 by 10.” The Wellness Pledge was adopted at a Wellness Summit held at Boston University in September, 2007. Through the promotion of wellness for people with mental illnesses, the pledge sought “to prevent and reduce early mortality by ten years over the next ten year time period, ”³³¹ or by 2017. Several studies point to an average of twenty five years of potential life lost by persons suffering from severe mental illness.³³² The Ohio study found an even higher loss of thirty-two years of persons who were admitted to a state hospital. By adopting aggressive integrated strategies with physical health, the goal is to cut the number of years lost by 40 percent within 10 years.

The NASMHPD Report set forth a strategy to transform the healthcare system in the United States. One of the underpinning strategies is the development of a Chronic Care Model. The Chronic Care Model is defined as a treatment approach in which a patient has “continuous, planned care that includes electronic information systems to track health status, decision support tools, measurement of performance indicators, and monitoring evidenced-based care protocols. Care management is provided to educate and support the individual to become a partner in healthcare decision making, adopt self-management strategies for health promotion and living well with chronic disease, and access community resources.”³³³

A key feature of the model is the designation of the patient-centered medical home that “would bring together a primary care physician, the bio/psychosocial/spiritual model of care, behavioral health services and disease management strategies based on the Chronic Care Model. Collaborative care could occur in a ‘virtual’ healthcare home, rather than a single physical location, where everyone involved in a person’s care coordinates their services and specifies responsibility for care management activities.”³³⁴ The NASMHPD Report noted, “Increasingly, reimbursement and regulatory systems are creating incentives and regulations that reward practitioners engaged in delivering medical home services.” Among the regulations established are certification standards developed by the National Committee for Quality Assurance.³³⁵

Behavioral Risk Factor Surveillance System

A key strategy is to align mental health services with public health activities which are designed to measure and prevent health care issues in the general population. The alignment needs to take place at the federal, state, and local level for maximum

³³⁰ Ibid.

³³¹ Ibid., p. 2.

³³² National Council for Community Behavioral Healthcare, *An Avoidable Tragedy-The Relationship of Premature Death and Serious Mental Illness*, Fact Sheet, June, 2007.

³³³ Joseph Parks, p. 6-7.

³³⁴ Ibid., p. 7.

³³⁵ Ibid.

effectiveness. As an example, The Behavioral Risk Factor Surveillance System (BRFSS) now includes questions related to mental health issues. The BRFSS is a joint project of the national Centers for Disease Control and Prevention (CDC) and the states' Departments of Health. The BRFSS examines the prevalence of certain health risk factors throughout the United States. The BRFSS provides information on health trends, the risk of certain chronic diseases as well as a measurement of the effectiveness of policies, health programs and public health awareness campaigns. The first BRFSS was completed in 1984, and though the instrument has been refined over the years, the instrument is based on a set of core questions related to health status, access to health care, health awareness, lifestyle and preventative health activities.³³⁶

The Ohio BRFSS is housed within the Ohio Department of Health. The Ohio BRFSS monitors the behaviors that are associated with the major causes of preventable morbidity and mortality among adults over the age of 18 in Ohio. The major causes include: heart disease, cancer, diabetes and injuries. Data for the Ohio BRFSS is obtained from telephone surveys where the interviewee is asked information in three parts: core questions, standardized modules and the Ohio-specific added questions. The core questions include inquiries as to tobacco and alcohol use, women's health issues, HIV/AIDS awareness and attitudes, and selected medical conditions. The standardized modules focus on weight control, quality of life, participation in leisure time and physical activities and the use of smokeless tobacco. The state-specific questions that Ohio adds include violence prevention, smoking policies, and questions regarding mental health issues.³³⁷

As a result, the BRFSS has documented that "persons in the general population with serious psychological distress/depression...have higher rates of health risk factors (smoking, obesity, physical inactivity) and chronic disease (diabetes, cardiovascular disease, asthma) as well as lower rates of utilization of preventative and self care."³³⁸

The 2008 Ohio Family Health Survey Special Population Report examined the health experience of persons with serious psychological distress based on a six item scale developed for epidemiological studies by the National Institute of Mental Health, CDC, and the World Health Organization. The 2008 Report determined that 5.4 percent of adults in Ohio reported experiencing at least twenty days a month of functional impairment due to serious psychological distress; an estimate of 460,000 adult Ohioans.³³⁹

In Ohio, 62 percent of persons with serious psychological distress reported living below 150 percent of the Federal Poverty level compared to 28 percent for the total population. Over three-fourths of persons with serious psychological distress reported

³³⁶ U.S. Centers for Disease Control and Prevention Web Site, <http://www.cdc.gov/brfss/about.htm>.

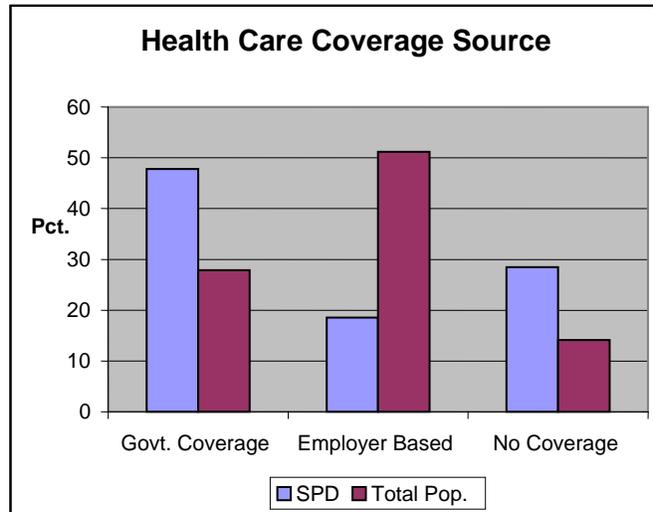
³³⁷ Ohio Department of Health Web Site, www.odh.gov/odhPrograms/svio/behrisk/behrisk1.aspx.

³³⁸ Joseph Parks, p. 6-7.

³³⁹ *2008 Ohio Family Health Survey Special Population Report: Persons with Serious Psychological Distress*: Ohio Department of Mental Health and Health Policy Institute of Ohio, State of Ohio Department of Insurance, Dept of Job and Family Services and Department of Health.

being unemployed. While 48 percent reported having a government-sponsored health care coverage (principally Medicare, Medicaid or both), 28 percent reported having no health care coverage. The percentage with no health care coverage for persons with serious psychological distress was double that of the total population.³⁴⁰ See Figure No. 76.

Figure No. 76.



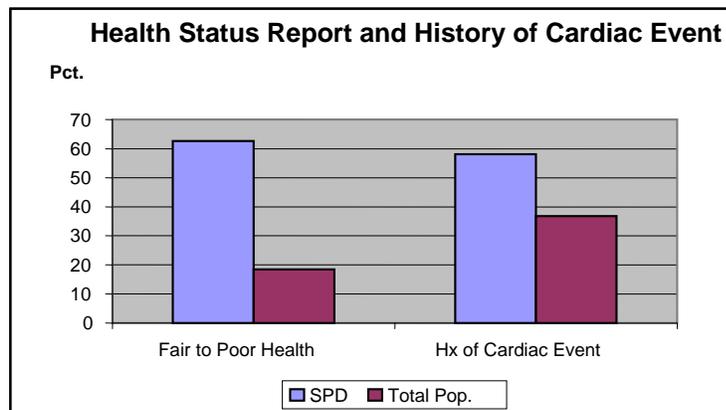
Source: 2008 Ohio Family Health Survey Special Population Report: Persons with Serious Psychological Distress (SPD)
 Note: Government Coverage includes: Medicare, Medicaid or both

In Ohio, the majority (63 percent) of the respondents with serious psychological distress reported their general health was fair to poor, compared to only 19 percent of the total population. Nearly 60 percent (58.12 percent) of persons with serious psychological distress reported a history of a cardiac event including at least one of the following: hypertension, heart attack, congestive heart failure, coronary heart disease, or stroke.) Only just over one-third (36.81 percent) of the total population reported a history of a cardiac event.³⁴¹ See Figure No. 77 on the next page.

³⁴⁰ ibid.

³⁴¹ ibid.

Figure No. 77.



Source: 2008 Ohio Family Health Survey Special Population Report:
Persons with Serious Psychological Distress (SPD)
Note: History of Cardiac Event includes: hypertension, heart attack,
Coronary Heart Disease, Stroke, or Congestive Heart Failure)

Persons with serious psychological distress reported twice as often having history of diabetes as the total population (22 percent to 11 percent). A history of cancer was reported by persons with serious psychological distress at a higher percentage than the total population (13 percent vs. 10 percent).³⁴²

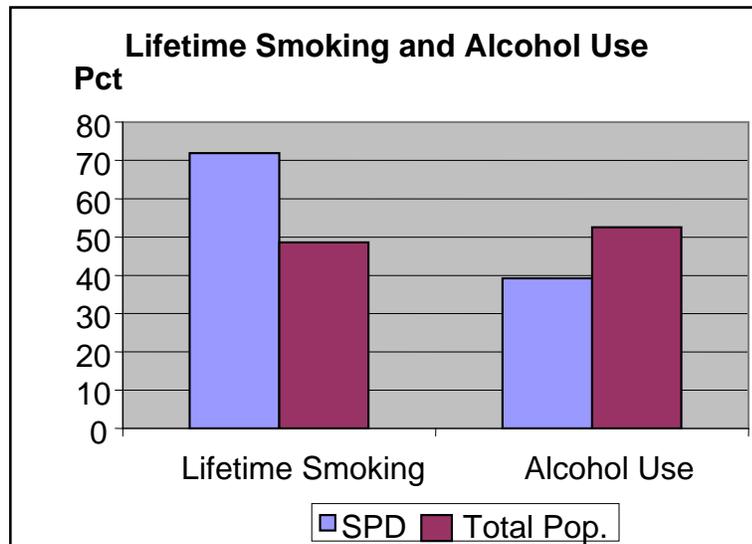
In terms of health risk behaviors, nearly 72 percent of persons with serious psychological distress reported a lifetime history of smoking tobacco compared to less than half (49 percent) for the total population.³⁴³ Of those persons who have ever smoked before, nearly 60 percent reported currently smoking on a daily basis, compared to just under 40 percent for the total population. See Figure No. 78 on the next page. At the same time, a higher percentage of persons with serious psychological distress reported not drinking alcohol compared to the total population (61 percent to 47 percent).³⁴⁴

³⁴² ibid.

³⁴³ ibid., lifetime history of smoking defined as smoking at least one hundred cigarettes in a lifetime.

³⁴⁴ ibid., alcohol use defined as one or more drinks in the past 30 days.

Figure No. 78.



Source: 2008 Ohio Family Health Survey Special Population Report: Persons with Serious Psychological Distress (SPD)
Note: Lifetime smoking defined as over 100 cigarettes; Alcohol use defined as one or more drinks in the past 30 days.

Sixty-nine percent of persons with serious psychological distress reported their physical weight as being either overweight or obese. Just under 39 percent identified their weight as obese, compared to just 29 percent of the total population. Less than one-third of persons with serious psychological distress described their weight as normal/ healthy or underweight.³⁴⁵

Persons having serious psychological distress reported three times more non-intimate and intimate partner violence than the total population (11 percent to 3 percent). Though the percentages are thankfully relatively low for all populations, this result is consistent with the Teplin, et. al., 2005 study, which found a higher incidence of victimization among persons with mental illness.³⁴⁶

Regarding access to care, while persons with serious psychological distress reported similar access to health care as the total population (84 percent), where they solicited treatment differed. Persons with serious psychological distress reported over twice as often using the hospital emergency room as the total population (16 percent to six

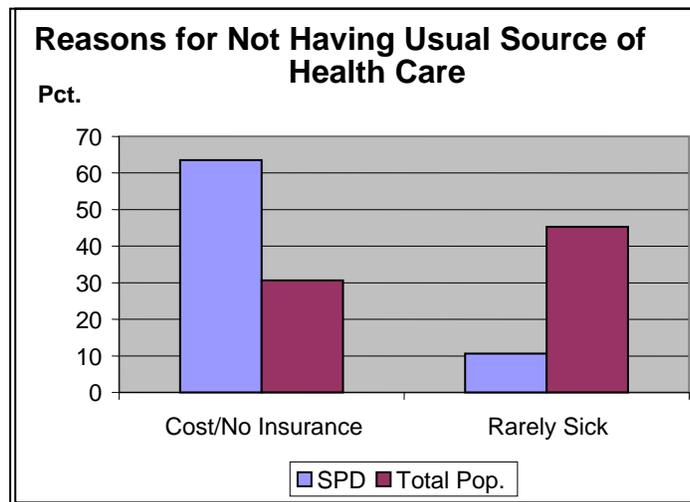
³⁴⁵ *Ibid.*

³⁴⁶ *Ibid.*, see Linda Teplin, et al., "Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey," *Archives of General Psychiatry*, Vol. 62, August, 2005, p. 914.

percent). At the same time, while the doctor's office or HMO was the most frequently cited source of care, persons with serious psychological distress were less likely to identify this source of care than the total population (74 percent to 56 percent). Persons with serious psychological distress reported slightly more often using a clinic or health center as their source of care than the total population (19 percent vs. 13 percent).³⁴⁷

Of the 16 percent of respondents who noted they did not have a usual source of care, persons with serious psychological distress were twice as likely to cite cost and no insurance as the reason compared to the total population (63 percent vs. 31 percent). The total population was far more likely to cite that they seldom or never get sick as the reason (45 percent vs. 11 percent).³⁴⁸ See Figure No. 79.

Figure No. 79.



Source: 2008 Ohio Family Health Survey Special Population Report: Persons with Serious Psychological Distress (SPD)

Just under one-half (43 percent) of persons with serious psychological distress reported that they needed mental health care, and of those who reported needing care, eleven percent indicated they did not receive said care. Once again, cost and no insurance were the most frequently reasons cited for not receiving said care (73 percent).³⁴⁹

³⁴⁷ ibid.

³⁴⁸ ibid.

³⁴⁹ ibid.

Wellness Summit

The 2007 NASMHPD Wellness Summit defined guiding principles that included the selection and implementation of health indicators which are closely aligned with the BRFSS. Coupled with the Fundamental Concepts of Recovery, the Dimensions of Wellness would provide the foundation for all service models and interventions. The six Dimensions of Wellness include: Social, Occupational, Spiritual, Physical, Intellectual, and Emotional.³⁵⁰

The physical dimension of wellness “recognizes the need for regular physical activity...encourages learning about diet and nutrition while discouraging the use of tobacco, drugs and excessive alcohol consumption...entails personal responsibility and care for minor illnesses and also knowing when professional medical attention is needed...”³⁵¹ The tenets of physical wellness include being physically fit and consuming food and other substances that enhance rather than detract from physical health.

The Wellness Summit adopted a basic set of health and process indicators that are recommended to be utilized when any person older than eighteen years of age enters into or is currently being treated within the mental health system. The basic set of indicators applies to both inpatient and outpatient settings with only slight adjustments in the outpatient settings for triggers that call for a test to be performed.

The basic health indicators include:

- 1) Personal history of diabetes, hypertension, and cardiovascular disease;
- 2) Family history of any of the above medical conditions;
- 3) Weight/Height/Body Mass Index;
- 4) Blood Pressure;
- 5) Blood Glucose or HbA1C;
- 6) Lipid profile;
- 7) Tobacco use or history;
- 8) Substance use or history;
- 9) Medication history and current medication list;
- 10) Social supports.

The basic process indicators include:

- 1) Screening and monitoring of risk and selected health conditions in MH settings;
- 2) Access to and utilization of primary care services.³⁵²

The Wellness Summit further recommended that the above indicators be field tested. Recognizing that states were at different levels of readiness, levels were established.

³⁵⁰ Joseph Parks, p. 22-24.

³⁵¹ Ibid., p. 24.

³⁵² Ibid., p. 11-12.

Ohio was included in the second level which would “incorporate indicator and measurement information into the hospital discharge planning process” per the “Joint Commission ORYX® initiative with communication to both the mental health provider and the primary care provider in the community.”³⁵³ The two continuing care plan measures that could be used would require the inclusion of four components: “discharge diagnosis, discharge medications, reason for hospitalization, and recommendations for next level of care.” In addition, the measures could examine how often this information was provided to the next primary care provider, i.e. both mental health and primary health care, within five days post discharge.³⁵⁴

On the national level, NASMHPD recommended that states implement the health and process indicators by the end of calendar year 2009, and complete the evaluation and dissemination of the initiatives by the end of 2010. While the testing was underway, the NASHMPD also recommended the adoption of proven population surveillance tools and engaging public health and healthcare leadership in action.³⁵⁵

While the national initiatives are underway, across the country considerable progress has been made at developing several models of integrated clinical care, including: the Integrated Collaborative Care Model, the Unified Program Model, the Embedded Model, the Co-Location Model, and unique or hybrid models.³⁵⁶ As the development of the integration of physical health and mental health has been underway for only the past two or three years, no single model has emerged as superior to another; nor should one model be considered to work for everyone. A cookie cutter approach will not work. There is plenty of synergy and creativity to allow for the development of effective integration models that fit the needs of each community.

The Integrated Collaborative Care Model involves the establishment of a well defined working relationship and commitment between separately run primary healthcare providers and the mental health provider. A key dimension of the Integrated Collaborative Care Model are the initiatives that are undertaken between independently operated, office-based primary care and public mental health providers.³⁵⁷ The collaborative challenge is more difficult “when providers practice separately and have separate administrative structures, information systems and funding sources.” At the same time, the Integrated Collaborative Care Model is considered the least disruptive to the traditional way of conducting business, and as such, may serve as the initial step toward integration. Four state Medicaid programs are working to address funding issues that are inherent in the “coordination of primary care and behavioral health for people with serious mental disorders;”³⁵⁸ the states are Massachusetts, Michigan, Oregon, and Oklahoma.

³⁵³ *Ibid.*, p. 13.

³⁵⁴ *Ibid.*, p. 36.

³⁵⁵ *Ibid.*, p. 16.

³⁵⁶ Elaine Alfano, *Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders*, Executive Summary, Bazelon Center for Mental Health Law, June, 2004, p.3.

³⁵⁷ *Ibid.*, p. 4.

³⁵⁸ *Ibid.*, p. 7.

The Unified Program Model involves a single administrative entity that coordinates both the mental health and primary care services. The Unified Model “is the most seamless approach of the models...integrating not only delivery of care but also administration and financing.”³⁵⁹ The Unified Program Model can resolve the barriers of resources and productivity, as “Providers are paid through the agency for time that is required for collaboration, including reimbursement for in-person attendance at case-planning team meetings. Unified arrangements are economically efficient, offering opportunities for administrative saving and physical plant efficiencies.”³⁶⁰ The Bazelon Center for Mental Health Law highlighted the Cherokee Health Systems in Tennessee as a demonstration of a program that is able to overcome financing barriers. The Cherokee Health System is a community mental health system and a federally qualified community health center. The Cherokee Health System provides integrated health care services at its twenty-one sites and receives reimbursement from its payers to cover its costs. The program is also eligible to receive additional funding for being located in a rural area (near the Smoky Mountains) and serving an underserved population, i.e. Native Americans.³⁶¹

The Embedded, Co-Location, or Medical Model can include either primary care services taking place at a mental health facility or mental health services being delivered at a primary care setting.³⁶² The Bazelon Center for Mental Health law found, “The embedding of primary care in a mental health program ensures strong working linkages between primary care and mental health providers and is particularly appropriate for adults with serious mental illnesses, whose primary contact with the health system is through their mental health provider.”³⁶³ Further, mental health clients may have difficulty steering through the maze of physical health care services. “This is particularly true if the consumer experiences competing uncoordinated demands in keeping up with the management of mental and physical well being.”³⁶⁴ The concept of a “Medical Home” is one way to remove barriers for mental health clients to receive needed services. The Medical Home can be located in the community mental health center if that is the location where the client more frequently receives services. The converse can also be true. If a client receives the majority of services from the community health center or similar setting, then this setting could serve as the Medical Home. If the Medical Home is located in a community mental health center, then physical health services could be embedded into the community mental health center. If the Medical Home is the community health center, then mental health services could be embedded there. The client’s primary medical home will usually determine the embedded arrangement that works most effectively for each client.

Additional considerations that need to be addressed in the development of an integrated program include:

³⁵⁹ *Ibid.*, p. 5-6.

³⁶⁰ *Ibid.*, p. 6.

³⁶¹ *Ibid.*

³⁶² Joanne Fuccello, *Directions in Mental Health and Primary Care Integration in Ohio*, Health Policy Institute of Ohio, September, 2007, p. 6.

³⁶³ Elaine Alfano, p. 5.

³⁶⁴ Anita Everett, et. al. *Improving the Health of Mental Health Consumers: Effective Policies and Practices*, Boston University, Center for Psychiatric Rehabilitation, December 17, 2007, p. 8-9.

- 1) Implement initiatives to improve communication and understanding between the physical health and mental health fields.
- 2) Streamline consents for information sharing by clients giving consent.
- 3) Provide physical health providers with current information about local mental health resources;
- 4) Facilitate consultations between physical health and mental health professionals;
- 5) Adjust funding strategies that include performance measures and incentives.
- 6) Provide cross training continuing educational programs.³⁶⁵
- 7) Provide cross training on Ohio's revised law that permits the exchange of psychiatric records and other pertinent information. (§5122.31 (7))

The present status of improved clinical integrated care within Ohio shows promise as evidenced by the development of many best practices models in the state. The Ohio Coordinating Center for Integrating Care (OCCIC) was created by the Ohio Department of Mental Health “to share information and resources about integrating and coordinating physical and mental health care in Ohio. OCCIC helps providers and communities identify needs, plan integrated care solutions, and share successes and obstacles.”³⁶⁶

OCCIC is a resource for Ohio's mental health providers and communities who are interested in creating innovative programs that integrate physical health care with mental health treatment. OCCIC has five areas of responsibility:

- **Share information:** OCCIC provides networking opportunities, training, and technical assistance to providers, payers, consumers, family members, and other stakeholders.
- **Determine need and solutions:** OCCIC helps providers and communities determine what their individual needs are and what options exist to help them meet those needs.
- **Connect providers and other stakeholders:** OCCIC helps providers, payers, decision makers, and other interested people come together to discuss the issues around integrated care and share ideas and information.
- **Advocate for integrated care:** OCCIC works with all interested stakeholders in advocating for integrated physical and behavioral health.
- **Evaluate efficacy:** OCCIC helps providers and communities collect, analyze, and share quality improvement, program evaluation, and consumer outcomes data.³⁶⁷

The OCCIC noted, “many people are critical to successful integrated care programs: providers, consumers, family members, community mental health boards, Coordinating Centers of Excellence (CCOE), policymakers, medical professionals, Federally Qualified Health Centers (FQHC), hospitals, and others. OCCIC will work with all stakeholders to spread the word and implement a variety of programs and resources for

³⁶⁵ Elaine Alfano, p. 9.

³⁶⁶ Health Foundation of Greater Cincinnati, *Ohio Coordinating Center for Integrating Care*, 2009.

³⁶⁷ Ibid.

integrated care.”³⁶⁸ The OCCIC is operated under the auspices of the Health Foundation of Greater Cincinnati.

The OCCIC compiled a list of 26 integrating programs within 21 agencies throughout Ohio as of the end of April, 2009. By the end of the state fiscal year 2009, the OCCIC anticipates to have 41 programs in operation in Ohio.³⁶⁹ The current integrated models in Ohio can generally be clustered into one of the evolving national models including: the Integrated Collaborative Care Model, Unified Program Model, the Embedded or Co-Location Model, or other models

Each of the current programs is briefly summarized by their model, region and agency. A detailed description of each of these programs is in the *Identifying Current Ohio Practices in Integrating Care, April, 2009* by the Ohio Coordinating Center for Integrating Care.

Integrated Care Model

- 1) Centerpoint Health in Hamilton County provides outpatient counseling, case management, and supportive, crisis, and prevention services to children and adults. Centerpoint provides on-site integrated services. The agency serves approximately 9,000 persons. The majority also receive psychiatric services. Centerpoint provides physical health treatment facilities at two of its locations where staff from Healthcare Connection, Inc., a federally qualified health center, attends to the clients’ physical health needs.
- 2) Talbert House operates eleven sites in affiliation with Centerpoint Health to provide integrated services to clients in Hamilton, Butler, Brown, Clermont, and Warren Counties in Ohio as well as Kenton County in Kentucky.
- 3) Recovery Center of Hamilton County is a consumer run organization that provides a wide range of supportive services including wellness classes and exercise programs.
- 4) Gathering Hope House in Lorain County developed a Happy Bucks Exercise Incentive Program. The consumers earn ‘Happy Bucks’ through their participation in an exercise program. The ‘Happy Bucks’ can then be redeemed for a variety of transportation or healthy lifestyle needs. Gathering Hope House also utilizes nursing students from the local community college who provide psycho-educational groups and teach the Gathering Hope House staff about health education programs. Gathering Hope House also provides a fitness center that is open to staff, clients and the greater community.

³⁶⁸ Ibid.

³⁶⁹ Ohio Coordinating Center for Integrating Care, *Identifying Current Ohio Practices in Integrating Care, April, 2009.*

- 5) Online Training for Physicians Treating Older Adults is web-based and comprised of four modules that cover psychiatric illnesses commonly seen in older adults. The modules are geared toward primary care and internal medicine physicians. The program was initiated by the Columbiana County Mental Health and Recovery Services, and being on line is available to any interested physician.
- 6) Community Support Services, Inc., located in Summit County provides an integrated clinic of mental health, primary care and pharmacy services. The center partnered with a local pharmacy, area universities, a foundation and a physician's group to provide these comprehensive services.
- 7) Community Health Center and Family Practice, located in Summit County provides healthcare services to over three thousand residents who suffer from compulsive and addictive behaviors.
- 8) North Central Mental Health Services, located in Franklin County provides a Nurse Outreach Team to provide integrated mental and physical health care. The Nurse Outreach Team serves 100 clients.
- 9) Free Clinic of Greater Cleveland, located in Cuyahoga County provides medical services, including HIV treatment and counseling, dental, psychiatric and substance abuse education and treatment. Over ten percent of the Free Clinic's clients have a substance abuse or mental illness disorder.
- 10) Wellness Management and Recovery Coordinating Center of Excellence, located at Southeast, Inc. in Franklin County provides a ten week group program to assist persons in learning about healthy living, and supporting each other in achieving personal goals. The program is a joint partnership with Southeast, the University of Toledo, and the Lorain County Community Mental Health Board.
- 11) Community Behavioral Health, located in Butler County, partnered with the Fort Hamilton Healthcare Corporation to provide the Community First Pharmacy for its clients. Community Behavioral Health also provides physical health screenings and referrals.
- 12) Health Resource Center of Cincinnati, located in Hamilton County, provides integrated medical, mental health, and substance abuse services to nearly five hundred homeless persons.

Embedded Model

- 1) Clermont Counseling Center, in Clermont County partnered with a local federally qualified health center (FQHC) to provide physical health services to its clients. The partnership has been in operation since 2007 and has served over five hundred clients to date.

- 2) Consumer Wellness Program within the Greater Cincinnati Behavioral Health Services, Hamilton County, is operated by a federally qualified health center. The Wellness program is currently serving six hundred clients and seeks to double the number this year

Unified Models

- 1) Harbor Behavioral Healthcare of Lucas County provides primary health care at one of its mental health center locations. Harbor Behavioral Healthcare employs the physical health service staff.
- 2) The Counseling Center, located in Scioto County, operates the Family Health Care Center that provides primary care services.
- 3) Get Connected Program, operated by Mental Health America of Franklin County provides a ten week psycho-educational program of physical wellness.

Other Models

- 1) The Center for Individual and Family Services, located in Richland County provides wellness services to its clients and staff.
- 2) The Center for Evidence-Based Practice at Case, located in Cuyahoga County provides the Tobacco Recovery Across the Continuum (TRAC) consumer led program. The program is implemented in twelve agencies across the state.
- 3) Assertive Community Treatment Teams (ACT), located in several counties provide physical health monitoring and facilitate access to physical health services as part of their case management services.
- 4) Ohio School Based Health Care Association, headquartered in Columbus provides twenty six school based health centers including mobile units in Columbus and Cleveland.³⁷⁰

In addition, to the programs identified by the OCCIC, the following programs also represent concerted efforts to effect integration of physical and mental health care:

- 1) Cleveland Coalition for Pediatric Mental Health's mission is to "engage and support pediatric primary mental health care providers to better address the health needs of children and their families' through standardized and routine screening for behavioral, emotional and mental health issues by enhancing primary care expertise in these areas of care and by improving linkages

³⁷⁰ Ibid.

between and among primary care providers and local behavioral/mental health resources.”³⁷¹

- 3) The Southeast, Inc., in Franklin County is providing integrated services to homeless persons who have a serious mental illness.
- 4) The Grant Medical Center Family Practice Clinic, also in Franklin County provides a psychologist to assess the mental health needs of its patients.³⁷²
- 5) The Shawnee Mental Health Center in Scioto County provides integrated mental health and physical health care services using an embedded model for Ohioans who reside in Adams, Lawrence and Scioto counties.³⁷³

The Shawnee Mental Health Center, Southeast, Inc. and the Centers for Family and Children were among eleven grantees nationally to receive grants in the summer of 2009 to provide integrate care.³⁷⁴

Council of Medical Directors

Under the direction of Dr. Marion Sherman, the ODMH Medical Director, the chief clinical officers of the state psychiatric hospitals are examining was to better integrate physical health care in the facilities. Among the interventions planned are to survey each facility’s present state of medical facilities and services and to determine which facilities and services are most beneficial. Dr. Joy Stankowski, Chief Clinical Officer at Northcoast Northfield Campus is spearheading this effort.

As the integration of physical health and mental health services continues to gain traction and is implemented nearly universally, perhaps the next updated report will not need to focus on the integration of physical health but rather proudly mention it as a *fait accompli*.

Increased Demand on Emergency Services

The 2004 Report noted that in March 2004, an “online survey of members of the American College of Emergency Physicians, 70 percent of the 340 respondents cited an increase in people being admitted to the hospital and forced to wait in the emergency room until inpatient psychiatric beds are available.”³⁷⁵ The survey further reported, “Sixty percent reported that the increase in psychiatric patients being served in emergency rooms is negatively affecting access to emergency medical care for all

³⁷¹ Joanne Fuccello, *Direction in Mental Health and Primary Care Integration in Ohio*, Health Policy Institute of Ohio, 2007, p. 8.

³⁷² *Ibid.*, p. 9.

³⁷³ *Ibid.*, p. 10.

³⁷⁴ SAMSHA, Grant No. FON SM-09-011, CFDA No. 93.243, Primary and Behavioral Health Care Integration (PBHCI), June 1, 2009.

³⁷⁵ *The Crisis in Ohio’s Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004.

patients. Sixty-six percent also blamed state health care budget cutbacks and the decreasing number of psychiatric beds for the trend. One in ten emergency physicians said that there is nowhere else in their community where the mentally ill can get treated.”³⁷⁶

The National Association of State Mental Health Program Directors’ Focus Group Report in September, 2006 cited the grim assessment reported in *The Hartford Courant* that, “the nation’s emergency health care is...on the verge of collapse.”³⁷⁷ The issue for emergency departments stems from The Emergency Medical Treatment and Active Labor Act, commonly referred to as EMTALA. The EMTALA became federal law in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act. The EMTALA regulations apply to those emergency departments whose hospitals receive either Medicare or Medicaid payments from the U.S. Centers for Medicare and Medicaid Services (CMS); virtually every general hospital with an emergency department in Ohio.

The CMS noted, “Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual’s ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability or if the patient requests, an appropriate transfer should be implemented.”³⁷⁸

The National Association of State Mental Health Program Directors’ Focus Group related that a 2006 report of the Institute of Medicine’s Committee on the Future of Emergency Care in the United States Health System found “emergency department visits grew by 26 percent between 1993 and 2003, a period in which the U.S. population grew by 12 percent. At the same time 425 emergency departments (12.3% of the U.S. total) and 700 hospitals closed, reducing emergency capacity by almost 200,000 beds.”³⁷⁹

The 2004 Report also noted that in Ohio the emergency departments are increasingly the initial point of access for many persons in psychiatric crisis. The report stated that “while direct admissions by referring physicians to private psychiatric inpatient beds have decreased by 10 percent from 2000 to 2002, admissions to these beds from emergency departments have increased by 20 percent in the same period. For example, the six general hospital emergency rooms in Montgomery, Greene and Miami

³⁷⁶ American Psychiatric Association, The National Alliance for the Mentally Ill, and the National Mental Health Association Survey, March, 2004.

³⁷⁷ Emery citation of “Reports Warn Nation’s Emergency Care on the Critical List,” *The Hartford Courant*, June 15, 2006.

³⁷⁸ Centers for Medicare and Medicaid Services, *Overview EMTALA*, www.cms.hhs.gov/emtala.

³⁷⁹ Emery cited reference, “Hospital-based emergency care at the breaking point,” National Academy of Sciences Institute of Medicine, Committee on the Future of Emergency Care in the United States Health Systems, 2006.

counties saw fifty eight percent more psychiatric patients in 2001 than in 1999. Their total psychiatric volume, including patients admitted for at least one night, rose by 66 percent to 17,171. Similar patterns are seen in emergency care for children. Cincinnati Children's Hospital has seen an increase from 1,379 in 1999-2000 to 3,871 in 2003, making the hospital the nation's busiest pediatric emergency room for child psychiatry services."³⁸⁰ The 2004 report also noted that "a survey, conducted by the Greater Cincinnati Health Council, found that the overall average length of stay in emergency departments (triage to admission) of persons with a psychiatric condition as the primary diagnosis was five hours."³⁸¹

An NIMH-funded study conducted in 2008 by the Medical University of South Carolina looked at the prevalence of admissions through emergency departments as well as factors that may mitigate that recognized national trend. The yet to be published study examined the admission experiences in six states. The study found that the combination of partial hospitalization programming and the provision of psychiatric expertise in the general hospital emergency departments reduced the number of admissions through the emergency departments. Other factors that were found to reduce admissions were access to residential treatment as well as ready access to state hospital beds.³⁸²

North Carolina Medical Clearance Standards

The North Carolina Department of Health and Human Services adopted medical clearance guidelines in October, 2007 entitled, *Medical Clearance of Psychiatric and Addictive Disorders in the Emergency Department*. The North Carolina Guidelines were a collaborative effort involving physicians in the state's emergency departments, state psychiatric facilities and private practice psychiatrists. The Guidelines utilized a literature search and the findings and recommendations from other entities in the United States. The cover letter that accompanied the new standards stated, "It has been evident that the lack of consistent guidelines for medical clearance has added to the wait times in our emergency departments for many of our consumers needing transfer to state psychiatric facilities. It is the goal of these guidelines to offer consistent expectations for our physicians in our state and our emergency departments."³⁸³ The medical clearance guidelines indicated that the North Carolina state psychiatric facilities can and do provide treatment for co-morbid medical conditions. At the same time, there is an acknowledgement that the state psychiatric facilities are "significantly more limited

³⁸⁰ 2004 Crisis in Acute Care Report, p. 18.

³⁸¹ Greater Cincinnati Health Council, Psychiatric Service Capacity Survey Results, January, 2004.

³⁸² Richard C. Lindrooth, *The Tradeoff between Access to Community Treatment and Acute Hospitalizations of the Severely Mentally Ill*, Medical University of South Carolina, unpublished NIMH-funded study presented at The Ohio State University, December, 2008.

³⁸³ Brent Myers and Harold Carmel, Letter in reference to *Medical Clearance of Patients with Psychiatric and/or Addictive Disease Emergencies in the Emergency Department*, North Carolina Department of Health and Human Services, October 17, 2007.

than that of a general hospital and they are not equipped to manage acute life-threatening medical conditions.”³⁸⁴

The North Carolina medical clearance guidelines listed examples of medical conditions that may not be safely or effectively managed at their state psychiatric facilities. The conditions listed included but were not limited to:

1. Medical conditions requiring transfusion
2. recent head injury
3. evolving cerebral vascular accident, i.e. stroke
4. recent myocardial infarction requiring telemetric monitoring
5. evolving myocardial infarction or unstable angina
6. uncontrolled hypertensive crisis
7. acute drug intoxication
8. recent drug overdose resulting in medical instability
9. acute fracture requiring surgical repair
10. unexplained fever
11. diabetic ketoacidosis
12. condition requiring ventilator use
13. New York Heart Association Class III (marked limitation of any activity) or IV (any physical activity brings on discomfort and symptoms occur at rest) and heart failure
14. unexplained elevated white blood count
15. severe dehydration
16. hepatic encephalopathy
17. acute renal failure
18. unstable vital signs not related to a history of a chronic condition
19. acute infection in immuno-compromised patients
20. delirium tremens
21. blood alcohol greater than 300 (this level is not considered an absolute but should be considered “in the context of the clinical situation to determine if the patient is stable enough for transfer.”)
22. acute post – operative condition
23. sickle cell crisis
24. active contagious varicella infection
25. frank gastrointestinal bleeding
26. children with unstable juvenile onset diabetes mellitus
27. end stage liver disease
28. third trimester of pregnancy (physician to physician communication is recommended).³⁸⁵

³⁸⁴ North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, *Medical Clearance of Psychiatric and Addictive Disorders in the Emergency Department*, October 15, 2007, p. 1.

³⁸⁵ *Ibid.*, p. 1-2.

The North Carolina Guidelines advised, “The overall approach to the care of patients in the Emergency Department with psychiatric symptoms must be the same as that of patients presenting with medical symptoms. Patients with psychiatric symptoms should undergo a history...and a targeted physical examination. The findings of the history and physical examination should guide subsequent laboratory testing. The combined result of the history, physical examination and resultant laboratory testing constitutes the ‘medical clearance’ of the patient.”³⁸⁶ The North Carolina guidelines cautioned that the medical clearance determination “reflects short term, but not necessarily long term medical stability within the context of a transfer. Medical clearance does not ensure the absence of ongoing medical issues...but rather signifies the following:

- No acute, emergent medical cause has been uncovered as the cause of the patient’s psychiatric symptoms; and
- The patient is not experiencing a medical or surgical emergency; and
- The patient is medically stable for transfer
- The receiving facility has confirmed the availability of appropriate resources to monitor and treat what has been currently diagnosed.”³⁸⁷

The North Carolina medical clearance guidelines also distinguished between low and high risks for medical conditions that could cause psychiatric symptoms. The basic distinguishing features being: current age, age at onset, history of psychiatric illness, medical complaints, substance abuse use, and delirium conditions. The guidelines included special considerations for geriatric patients and those without a previous history of mental illness.³⁸⁸

Massachusetts College of Emergency Physicians Medical Clearance Statement

In Massachusetts, a joint task force recommendations of the College of Emergency Physicians and the state’s Psychiatric Society were adopted by the two professional bodies. The task force entitled their report, *Consensus Statement on Medical Clearance and Toxicology Screening*. Although the statement is undated, it was a primary source used by North Carolina in developing their guidelines. The consensus statement noted that they “agreed to make reference to and use of the EMTALA definition of the medical screening and stabilization exam. By that definition, transfer of the patient requires that the patient be medically stable for transfer or that the benefits of transfer outweigh the risks.”³⁸⁹

The Massachusetts task force also conducted an extensive literature review and they determined that “no consensus in the literature was found that delineated a proven, standardized approach to the evaluation and management of psychiatric patients

³⁸⁶ *Ibid.*, p. 2.

³⁸⁷ *Ibid.*

³⁸⁸ *Ibid.*, p. 2-3.

³⁸⁹ Massachusetts College of Emergency Physicians, *Consensus Statement on Medical Clearance and Toxicology Screening*, p. 1; obtained from web site: macep.org.

requiring medical evaluation in the emergency department. There was general agreement, based on clinical experience, to establish Criteria for Psychiatric Patients with Low Medical Risk.”³⁹⁰ The criteria included:

- Age between 15 and 55 years
- No acute medical complaints
- No new psychiatric or physical symptoms
- No evidence of a pattern of substance abuse
- Normal physical examination that included at a minimum:
 - Normal vital signs
 - Normal assessment of gait, strength and fluency of speech appropriate for the patient’s age
 - Normal assessment of memory and concentration that was age appropriate.³⁹¹

The consensus statement “agreed and recommended that routine diagnostic screening and application of medical technology for the patient who meets the above low medical risk criteria is of very low yield and therefore not recommended...a potential receiving facility’s request for additional diagnostic testing of the patient should be guided by that individual patient’s clinical presentation and physical findings and should not be based on a receiving facility’s screening protocol.”³⁹²

As with the North Carolina guidelines, the importance of physician to physician communication was stressed. The Massachusetts consensus statement further advised the development of database of regional psychiatric units denoting “the respective availability of concurrent medical care, nighttime and weekend medical coverage, locked and unlocked beds and separate and concurrent substance abuse treatment.”³⁹³

ODMH Medical Clearance Policy

On July 14, 2009, ODMH promulgated the “Medical Clearance Policy for Regional Psychiatric Hospitals for Admission of Patients- MD-17.” The policy is intended to “guide the Regional Psychiatric Hospital (RPH) admitting physician, in working with the ADAMHS Board designated referring physician or Community Mental Health Center (CMHC) pre-screener/designee to evaluate potentially complex, medically-compromised patients, and to determine the medical procedures or tests that may best occur prior to admission to a RPH...This policy will guide the requesting and admitting physicians through a problem-solving dialogue to determine a course of medical treatment in the

³⁹⁰ Ibid., p. 1-2.

³⁹¹ Ibid., p. 2.

³⁹² Ibid.

³⁹³ Ibid.

best clinical interest of the patient, while maintaining a collaborative relationship between healthcare providers.”³⁹⁴

Maine Medical Center and Spring Harbor Hospital, Maine

The staff of the Maine Medical Center and Spring Harbor Hospital, in Portland, Maine formed a multidisciplinary team that was charged with identifying “measures to decrease the emergency department (ED) length of stay (LOS) for patients requiring psychiatric inpatient admission from over 10 hours on average to 6 hours within 12 months.”³⁹⁵ A study of the interventions and their results was undertaken. The result of the interventions resulted in a decrease in the ED LOS from a peak of eighteen hours to just over six hours by June 2003. The study found that with the decline in the LOS “the overall need for security staff also decreased and compliance with JCAHO standards for restraint and seclusion increased dramatically.”³⁹⁶ The study noted these successes in spite of a thirty-seven percent increase in the number of admissions to the emergency department.

The interventions were classified based on their intended target, i.e. reduce length of stay or reduce the use of seclusion and restraint in the emergency department. Some interventions, i.e. staff training were useful for both targeted goals.

The reducing length of stay interventions were: streamlined and standardized clinical information collected, establishment of targets for LOS, standardized outpatient and inpatient assessment tools, medical clearance standards, movement of the pre-certification process to the inpatient psychiatric unit, creation of a multi-generational unit for increased flexibility in placement, and the formation of dedicated admission teams.³⁹⁷

The reduction in seclusion and restraint within the emergency department involved the interventions of: the establishment of an administrative and clinical psychiatric care teams, auditing one hundred percent of secluded and/or restrained patients’ charts, development of psychiatric standard of care guidelines, creation of a dedicated psychiatric nurse assignment, creating of a seclusion and restraint order sheet, and establishment of controlled access for a remodeled emergency department.³⁹⁸

³⁹⁴ ODMH, Medical Clearance Policy for Regional Psychiatric Hospitals for Admission of Patients- MD-17, July 14, 2009.

³⁹⁵ David Bachman, et. al., “Improvement Report: Reducing Length of Stay in the Emergency Department for Psychiatric Patients,” Maine Medical Center, presented at Institute for Healthcare Improvement National Forum, December, 2003. Obtained from IHI web site: ihi.org.

³⁹⁶ Ibid.

³⁹⁷ Ibid.

³⁹⁸ Ibid.

We Care Regional Crisis Center, Lima

An example of a well designed integration with the physical health system at the emergency department level is the We Care Regional Crisis Center program developed at St. Rita's Medical Center, at Lima. The 2004 report noted that at St. Rita's Medical Center, "community physicians, behavioral health leaders and professionals developed a shared psychiatric emergency service to provide a unified community approach to best practices and activities that would demonstrate clinical and fiscal effectiveness."³⁹⁹ This collaboration was born out of the increasing volume of clientele and extensive waiting periods for triage and services that plagued so many emergency departments.

The 2004 Report looked forward to the anticipated development of the program of a multi-agency project team that was put together "to implement a collaborative service model with eight essential components in conjunction with St. Rita's Medical Center, Lutheran Social Services and the Mental Health and Recovery Board of Allen, Auglaize and Hardin Counties."⁴⁰⁰

The 2004 report identified that "this centralized service will be located at St. Rita's Medical Center and will serve as a point of contact to provide rapid access to mental health/addiction services. The service components will include telephone crisis intervention, information and referral services; initial evaluation and emergency triage; 24/7 mental health and addiction assessment services; social service/case-management services; aftercare/bridge services; onsite pre-screening in the community; community outreach education/prevention services; and observation and placement services will be established in 2005. Both the Mental Health and Recovery Service Board and St. Rita's Medical Center will financially support the service and Lutheran Social Services will implement the Center. Contracts will be completed and the Advisory Committee established by June 2004. A Director, coordinators, professional and support staff will be hired by August 2004. The expected implementation date for services is September 2004."⁴⁰¹

In this updated report we are pleased to report some of the key outcomes from this multi-agency collaboration that started six years ago.⁴⁰² The historical problem that the new and innovative program hoped to ameliorate was the limited after hours and weekend behavioral health crisis services that were available in Allen, Auglaize and Hardin counties. As a result of the limited availability of these off-hour services, the emergency department at the St. Rita's Medical Center in Lima was inundated with persons needing these services. In FY 2003, the emergency department "treated over 5,000 persons who indicated they were suffering from a behavioral health crisis either as a primary or secondary problem...The numbers of persons presenting with a

³⁹⁹ *The Crisis in Ohio's Acute Mental Health Care Report*, 2004, p. 19.

⁴⁰⁰ *Ibid.*

⁴⁰¹ *Ibid.*

⁴⁰² Special thanks to Michael Schoenhofer, Executive Director of *the Mental Health and Recovery Services Board of Allen, Auglaize, and Hardin Counties*, and Kelly Monroe, MSSSA, LSW, Director of Emergency Services at the *We Care Crisis Center* for sharing their outcome information for this report.

behavioral health issue have been steadily increasing causing long waits at the emergency department.”⁴⁰³ The problem was further exacerbated as the “medical center staff was not adequately trained to deal effectively with behavioral health crises and thus many patients were inappropriately hospitalized and not linked with needed services.”⁴⁰⁴

The result was a situation existed “where some emergency department doctors practiced ‘defensive medicine’ and admitted patients because there are no other services available. This situation clearly pointed to the need for mental health and addiction professionals to be available to quickly assess and effectively treat persons in need. There was a desperate need to create a ‘one-stop’ regional access point serving residents in all three counties.”⁴⁰⁵

The We Care Regional Crisis Center opened on April 25, 2005. Among the services provided by the center were: Crisis Hotline and Information and Referral; Access to Client Information through the CATT system; Seamless care from the St. Rita’s Medical Center to the We Care Regional Crisis Center; Crisis counseling; Brief Therapy; and emergency medications for those who are short on their supply of medications. This service alone was considered an important intervention to avoid some inpatient hospital stays.⁴⁰⁶

The overall program goal was to “continue to increase assessments in crisis centers toward 50%.”⁴⁰⁷ Over the past three fiscal years (FY 2007 to 2009), the We Care Crisis Center has consistently handled 43 to 54 percent of the total referrals for psychiatric services. A key outcome is that whereas in FY 2003 the St. Rita’s Hospital emergency department was handling over 5,000 cases that needed psychiatric services, over the past three years the emergency department’s demand has been substantially reduced to just over 1,000 cases per year; a decline of seventy-eight percent.⁴⁰⁸ See Figure No. 80 on next page.

⁴⁰³ Kelly Monroe, We Care Regional Crisis Center, *Background Information Report*.

⁴⁰⁴ Ibid.

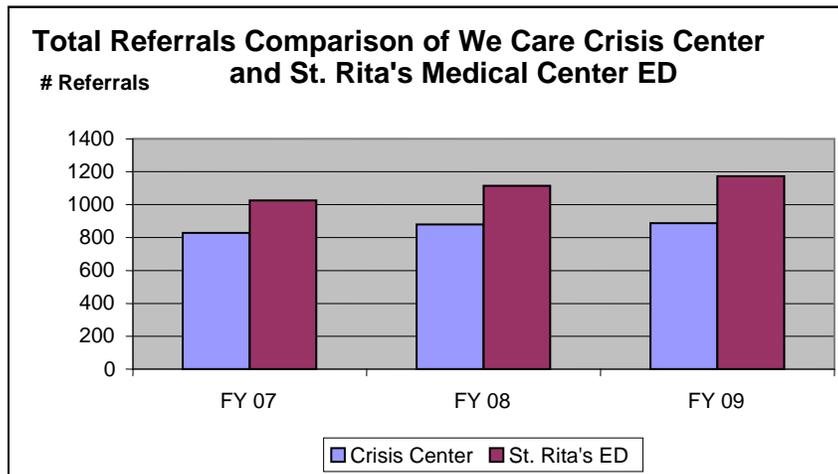
⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ We Care Regional Crisis Center, *Outcomes Reporting Form*.

⁴⁰⁸ Ibid., and *Background Information*.

Figure No. 80.



Note: FY 09 data is annualized based on actual results through February, 2009.
Source: We Care Regional Crisis Center Annual Reports and Outcomes Reporting Form

Another key indicator is the disposition of the cases seen by the respective entities. In FY 09, the We Care Crisis Center referred nearly sixty percent (58.2%) persons for out-patient services and only admitted for inpatient hospitalization just over forty percent (41.8%). Conversely, the St. Rita's Medical Center emergency department referred just over thirty percent (30.7%) for out-patient services and admitted for inpatient care nearly seventy percent (69.3%) of the cases seen.⁴⁰⁹

Though significant progress has been made, the primary impediment to the We Care Crisis Center achieving its goal of fifty percent of referrals is due to the high number of persons who are intoxicated and thus need to be routed through the hospital's emergency department for medical evaluation. In addition, a large number of referrals are sent in by emergency medical certificate which precludes the client being seen at the crisis center. These issues continue to be the focus for continued areas of improvement.

The We Care Regional Crisis Center is an example of an excellent model of collaboration between the mental health and physical health systems at the crucial point where the two systems frequently meet, i.e. psychiatric crises. The model may be especially useful in more rural areas of the state where resources and demand are less available than in more urban areas. It is an example of a regionalized approach to address the overburdening crisis of psychiatric services within an emergency department.

⁴⁰⁹ *Ibid.*, FY 09 Monthly Statistical Report.

Psychiatric Emergency Service within a Hospital Emergency Department

Another excellent model is the Psychiatric Emergency Services operated by the University of Cincinnati Hospitals. The Psychiatric Emergency Service is a multi-disciplinary team of professionals who provide assessment services for persons who come to the University Hospitals emergency department. A key service component within the emergency department is the availability of a mobile crisis team to respond in the community.⁴¹⁰ The Psychiatric Emergency Service team assists the emergency department physicians in determining the proper referral for persons who come to the emergency department and are in psychiatric distress.

Hospital Exemption - Convalescent Stay in Medicaid-certified Nursing Facilities

The U.S. Congress established the Pre-Admission Screening and Resident Review (PASRR) requirements to ensure that admission and retention of people with serious mental illness (SMI) in Medicaid-certified nursing facilities (NF) are appropriate. This federal mandate is a part of the Omnibus Budget Reconciliation Act (OBRA) 1987 commonly referred to as the Nursing Home Reform Act. Federal law (the Social Security Act, Section 1919E) and 42 Code of Federal Regulations (CFR), Chapter IV, Subpart C require states to have a PASRR program to determine whether nursing facility applicants have indications of SMI and/or developmental disabilities and other associated conditions, to ensure the most appropriate placement.

Medicaid - certified NF's are prohibited from admitting any person with indications of SMI unless the state mental health authority (SMHA) has determined that the person requires the level of services provided in an NF and does not require specialized services [for mental illness]. If the applicant requires specialized services, the SMHA must arrange for these services to be provided in a psychiatric unit licensed or operated by the SMHA. Medicaid reimbursement is not available for NF services that are provided to a person with indication of SMI who has not been screened and approved for the services provided in a NF.

The federal guidelines require that if Level I screening indicates the person may have a serious mental illness, a Level II evaluation and determination must be conducted. The Level II evaluation determines: whether the applicant have SMI, whether the applicant requires the level of services provided in a NF, and whether the applicant require specialized mental health services. Determinations must be made based on an evaluation conducted by an independent mental health professional. Persons with SMI who do not require the level of services provided in a NF or who require specialized mental health services may not be admitted.

The regulations allow states to make presumptive time-limited determinations known as categorical (advance group) determinations – Level II determinations based on categories for which intermediate nursing facility services are normally needed. Emergency admission and respite care are the two categorical determinations issued in

⁴¹⁰ University of Cincinnati Hospitals' web site: universityhospitalcincinnati.com/emergency.html.

Ohio. When issuing a categorical determination, states must specify an appropriate time limit for provisional admissions.

A person later determined to require a stay beyond that which was approved by the categorical determination must undergo an individualized Level II resident review before continuation of the stay is permitted and Medicaid payment is made for care beyond the approved stay. An emergency admission must not exceed seven days, and respite stays are not to exceed the approved 14-day stay.

It is important to note that the statutory definition of SMI for PASRR does not include persons with a primary diagnosis of dementia, including Alzheimer's disease and other organic brain disorders. The need for mental health services does not necessarily preclude a person from admission to a Medicaid-certified NF. If NF services are approved, the need for mental health services must be assessed. The NF is responsible to provide and/or arrange for routine mental health services, which are of a lesser degree than specialized services, in the same manner that the facility provides required other medical and social services.⁴¹¹

The PASRR provision has been in place since 1987, with subsequent revisions to the regulation in 1990, 1992, and 1996. For the initial fifteen years, the review process seemed to work well to assure that only the patients who needed the level of services that are provided in an NF were referred to an NF. All other persons were supported by the community mental health system. However, since 2002, a marked increase in the referrals of persons with SMI to NFs has taken place, not only in Ohio but across the country. Especially alarming is the growing number of younger adults with mental illness who are now being referred for nursing home placement.

The 2004 Report warned, "although there are many reasons that may cause a patient to fail to meet necessary nursing facility level of care requirements, the lack of appropriate continuity of care options, as well as the relentless pressure to shorten psychiatric inpatient lengths of stay as a result of fewer beds and inadequate reimbursements, have been identified as the primary variables."⁴¹² The reasons cited in 2004 would appear to be even more problematic six years later.

The Ohio experience of a three-fold increase in nursing home placements from psychiatric hospitals from 2002 to 2008 resulted in Ohio being ranked third in the nation in the number of younger mentally ill persons who are in nursing homes. The *Associated Press* analyzed the numbers of this growing trend in Ohio and across the country. The *Associated Press* found that Ohio's "nursing-home population of mentally ill adults between ages 22 and 64 grew by 9,361 last year (2008), an increase of 39

⁴¹¹ Omnibus Budget Reconciliation Act (OBRA) 1987, Public Law 100-203, Title IV, Subtitle C, Part 2, Section 4211 (a)(3).

⁴¹² *The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 20.

percent from 2002.”⁴¹³ The article also noted that Ohio’s growth rate ranked thirty-third across the country and “reflects a national trend spurred by the closing of state mental institutions, a shortage of psychiatric beds in hospitals and an increasing number of nursing home beds that are available because today’s healthier elderly are more likely to live in their homes.”⁴¹⁴ The Associated Press reported that according to the Centers for Medicare and Medicaid Services “nearly 125,000 young and middle-aged adults with SMI lived in U.S. nursing homes last year (2008).”⁴¹⁵

This influx of younger adult mentally ill persons into convalescent stay NFs raises legitimate questions as to the veracity of the practice as well as the impact. A benefit cited in support of the practice is that patients are able to be released from psychiatric hospitals sooner than they may have otherwise, especially if community supports cannot be made readily available. The practice might open up acute care beds that are in short supply. However, this practice fails to comply with the federal mandate of PASRR in which no person, with indication of SMI should be admitted to a NF, without having undergone a level II evaluation from ODMH; and found to require the level of services provided by a NF, and not to require specialized services for mental illness.

On the down side, the mixing of frail elderly adults with younger and physically stronger persons, mentally ill or otherwise, is a concern that is gaining increasing attention across the country. Many states can cite at least one tragic outcome. In Ohio in 2006 a 77-year old man was killed in a Toledo area NF by a younger adult who suffered from mental illness.⁴¹⁶ Tragic incidents such as this one raise questions as to whether NF are adequately staffed and able to provide the services needed to address the varied needs of elderly adults and younger mentally ill persons.

In addition, further analysis is needed to determine whether the community mental health system provides active aftercare follow up services during their clients’ NF stay. A key concern is where the person with mental illness resides and what services are made readily available upon release from the NF? If the community mental health system is not actively engaged there is an increased chance that the mentally ill person will “fall through the cracks” following release from the NF.

Finally, from a fiscal perspective, the rising costs of Medicaid and its impact may bring into question the practice. In the case of patients who were discharged from private psychiatric hospitals, Medicaid already paid for the patient’s hospital stay, and now Medicaid pays for a continuing stay and psychiatric services in a nursing home? Both hospital and nursing home services are among the more expensive Medicaid expenditures; exponentially more so than Community Medicaid.

⁴¹³ Associated Press, “Ohio 3rd in U.S. tally of Younger Mentally Ill in Nursing Homes” in *Columbus Dispatch*, March 28, 2009, B-5.

⁴¹⁴ *Ibid.*

⁴¹⁵ *Ibid.*

⁴¹⁶ *Ibid.*

PASRR is intended to ensure the appropriateness of continued stay in a Medicaid-certified NF. The hospital exemption permits a patient to be transferred from an acute care hospital for an up to 30-day stay in an NF. Before the 30 day trigger time, if a resident has been discharged from the NF or readmitted to a hospital or the NF withdraws a request for continued stay approval, then these cases would not be reviewed by PASRR. Thus, the PASRR data does not include the cases of hospitalized patients being discharged to NFs, unless the resident sought to remain in the NF beyond the allotted 30 days. This shortcoming has been addressed in the revised PASRR rules. The State now has a mechanism through which utilization of the hospital exemption is tracked. PASRR data will include access to NF services through the use of the hospital exemption. Effective December 1, 2009, form # 07000 must be completed by the hospital attending physician "no later than the date of discharge from the hospital certifying that all of the hospital (convalescent) exemption criteria as defined in paragraph (B)(9) of rule 5101:3-3-14 of the Ohio Administrative Code."⁴¹⁷ In addition, NFs are now required to submit a significant change resident review request whenever a resident is admitted to a psychiatric unit licensed or operated by ODMH.

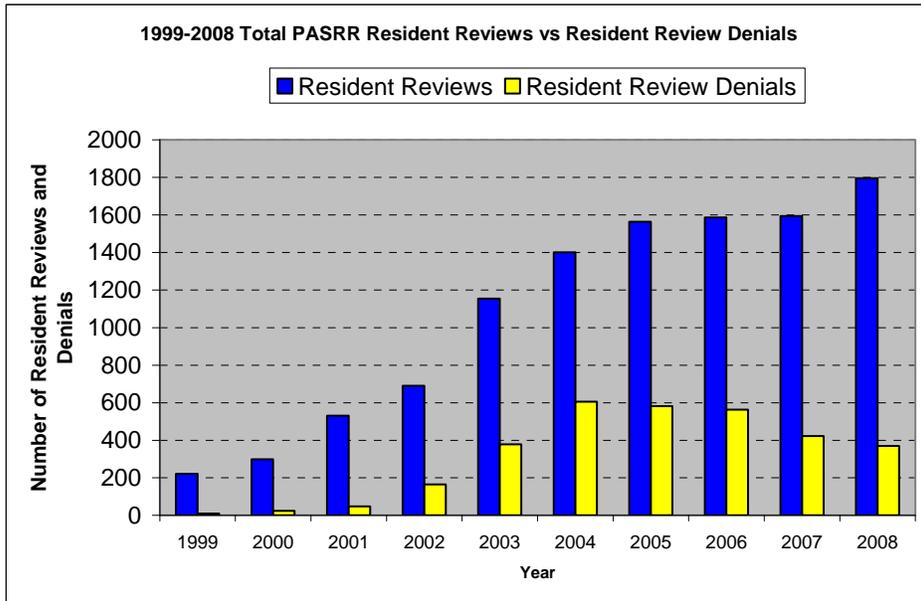
With this caveat, the 2004 Report indicated that the "Ohio PASRR data reveals a pattern of continuing increases in the number of total resident reviews received and processed by the state over the past five years. In a parallel fashion, the number and the percentage of resident reviews that are not approved, thereby resulting in denying a request for the continuation of nursing facility stay, have likewise increased. These denials for continued nursing facility residency involve patients that either need psychiatric hospitalization or can be best served with community-based services."⁴¹⁸

The experience in Ohio since 2004 indicates a continuing increase in the number of reviews conducted. However, while the number of reviews has consistently increased, the number of denials declined slightly from the high of 2004 (43 percent) to in 2005-2006 (37 and 35 percent respectively), and then dropped off precipitously in 2007 and 2008 (26 and 21 percent respectively). The reason for the decline in the denial rate is unclear. Further evaluation is necessary to determine the underlying factor(s). See Figure No. 81 on next page.

⁴¹⁷ Ohio Administrative Code § 5101:3-3-15.1 (G), effective December 1, 2009.

⁴¹⁸ *The Crisis in Ohio's Acute Mental Health Care: A Mental Health and Overall Health Problem*, Ohio Department of Mental Health, April, 2004, p. 20.

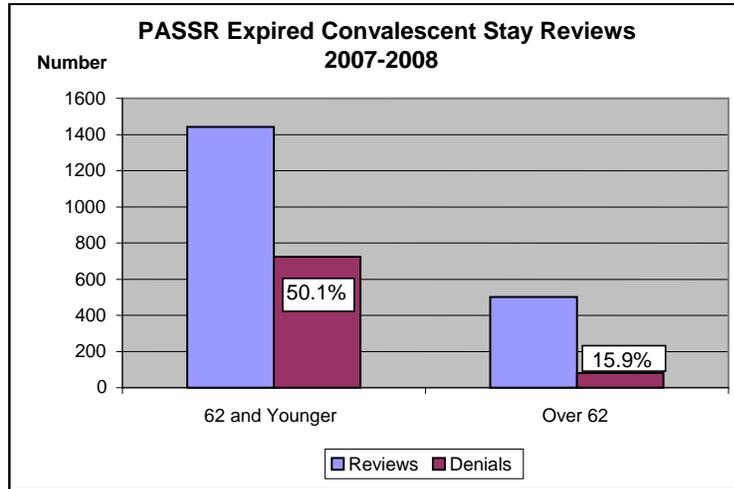
Figure No. 81.



Note: 2008 Data is annualized based on actual data through 10/08
Source: ODMH PASRR Office

Breaking down the PASRR review data for 2007 and 2008 by age group, we see that NF residents younger than 62 years of age, who were issued an adverse determination, comprised nearly three-fourths (74.2 percent) of the expired hospital exemption (convalescent stay) resident reviews and accounted for 90 percent of all the denials for extended stays. The age group of individuals younger than 62 had a 50 percent denial rate, while the age group of individuals older than 62 had only a 16 percent denial rate. See Figure No. 82 on the next page.

Figure No. 82.

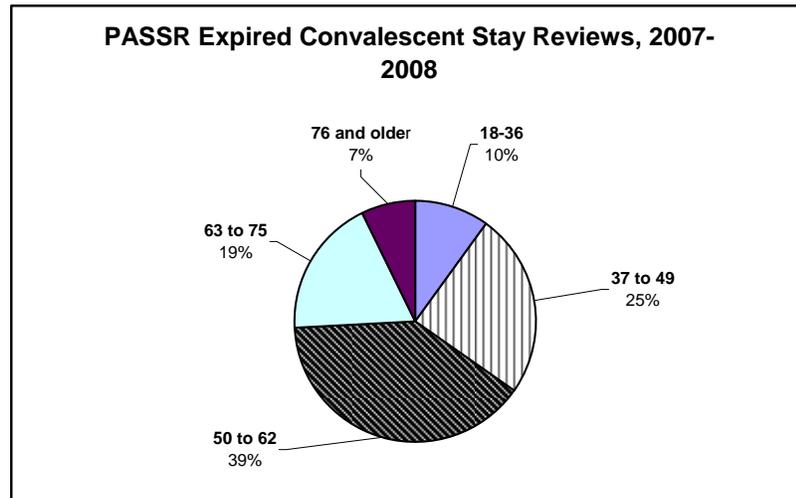


Source: ODMH, PASSR Office

Further analysis by more discreet age groups reveals that groups between the ages of 37 to 62 accounted for nearly two-thirds (64.1 percent) of all the expired hospital exemption (convalescent stay) resident reviews. The 50 to 62 age group accounted for nearly 40 percent of all the resident reviews. The 18 to 36 age group accounted for ten percent, and the age groups older than 62, accounted for the remaining 26 percent (25.7 percent). See Figure No. 83.

Figure No. 83.

PASSR Expired Convalescent Stay Reviews, by Age Group, 2007 - 2008

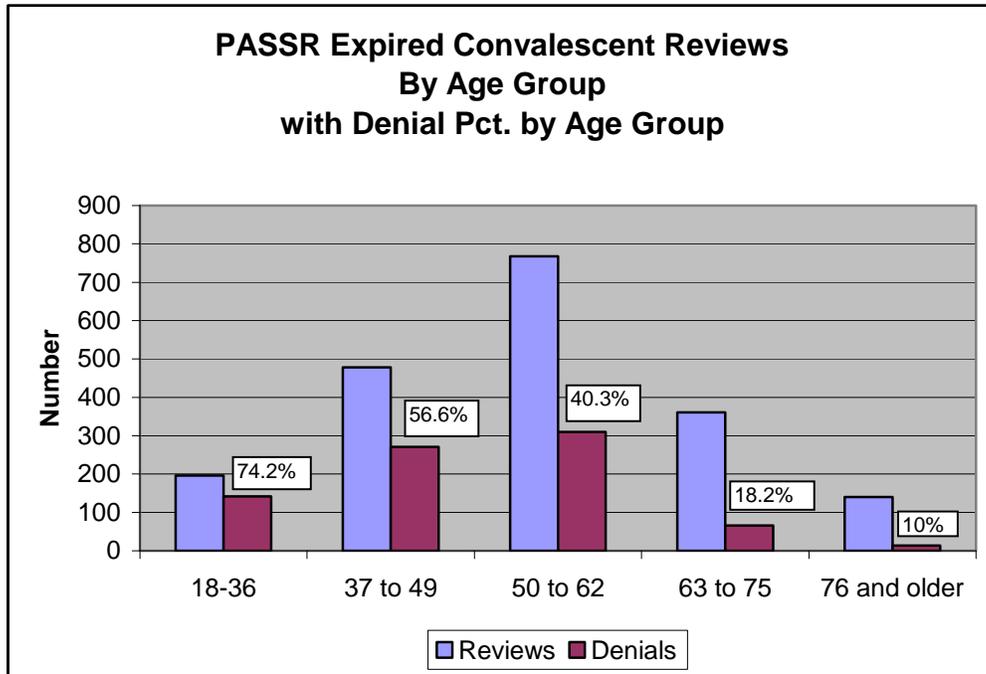


Source: ODMH, PASSR Office

Analysis broken down into more discreet age groups reveals a marked reduction in the percentage of denials the older the age group. The 18-36 age group had a 72.4 percent denial rate, while the 76 and over age group had only a 10 percent denial rate. See Figure No. 84.

Figure No. 84.

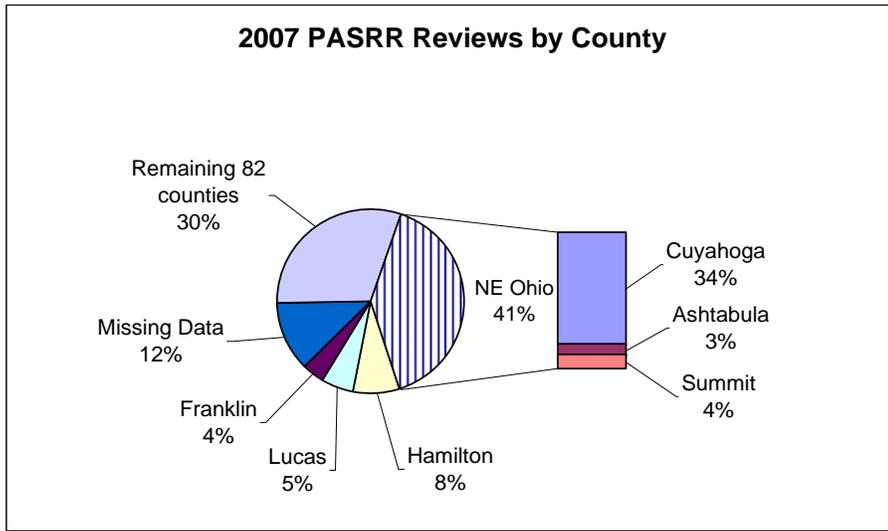
PASSR Expired Convalescent Reviews by Age Group (2007 to 2008)



Source: ODMH, PASSR Office

There is also a wide disparity of the PASRR reviews across the state. Three counties in northeast Ohio (Cuyahoga, Ashtabula, and Summit) accounted for 41 percent of all PASRR reviews in Ohio in 2007. See Figure No. 85 on the next page.

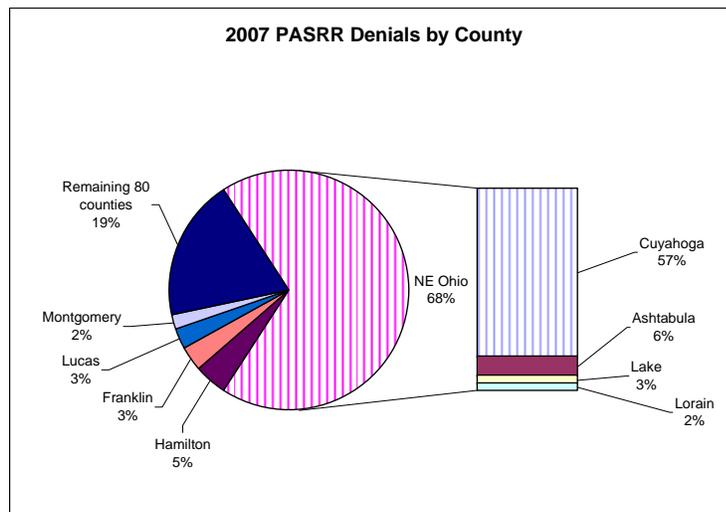
Figure No. 85.



Source: ODMH PASRR Office

An analysis of the denial data reveals that four counties in the northeastern region of the state (Cuyahoga, Ashtabula, Lorain, and Lake Counties) accounted for 68 percent of all PASRR denials in the state in 2007. See Figure No. 86.

Figure No. 86.



Source: ODMH PASRR Office

The percentage of denials to referrals for the six counties who had the highest number of PASRR reviews in 2007 is shown in the following chart. See Figure No. 87. There was a large variance between the six counties in terms of percentage of denials. Ashtabula County had the highest percentage of denials (54 percent) with Summit County having the lowest percentage (12 percent). The average number of reviews for

the six counties was 152 reviews, and the average number of denials for the six counties was 53 denials, or 35 percent of the reviews conducted.

Figure No. 87.

2007 PASSAR Reviews

County	Referrals	Denials	Pct
Cuyahoga	527	241	46%
Ashtabula	50	27	54%
Franklin	63	14	22%
Hamilton	130	19	15%
Lucas	85	11	13%
Summit	58	7	12%

Source: ODMH, Office of PASSAR Reviews

The practice of discharging patients from an acute care hospital to a Medicaid-certified NF is predominately a private hospital phenomenon. In FY 2008, there were a total of 6,008 discharges from the state hospital system. Of this number, thirty-nine or just over half of one percent (0.65 percent) were discharged to a Medicaid-certified NF facility,⁴¹⁹ after undergoing a Pre-Admission Screening. During FY 2008, the PASRR Unit completed a total of fifty-five reviews of requests for discharge to a Medicaid-certified NF from a state hospital. The denial rate was nearly one-third (32.7 percent). The PASRR reviews by state hospital and the percentage of denials are shown in Table No. 88.

Table No. 88.

FY 2008 PASRR Applications Processed from State Hospitals

State Hospital	Total PASRR for FY 2008	Percentage of Denials
ABH-Athens	2	50.0%
ABH-Cambridge	3	33.0%
HBH	6	66.7%
NBH-Northfield	4	25.0%
NBH-Toledo	11	36.4%
SBH	11	9.1%
TVBH-Columbus	8	25.0%
TVBH-Dayton	10	40.0%
Total	55	Combined Denials =32.7%

Source: ODMH PASRR Office

⁴¹⁹ Patient Care System, Discharge Living Arrangements for all Discharges in FY 2008.

Part VII Integration within the Physical Health System Key Points

1) The integration of physical health and mental health services is gaining increased acceptance across the country and in Ohio. The implementation models continue to be developed, all of which can be tailored to a communities' unique needs, culture and service delivery systems. The need is well researched and established. The former two isolated silos of care are slowly giving way to a more integrated approach that seeks to support and treat the wellness of all the client's needs.

2) The OCCIC tracks the development of innovative and community based integration with physical health models across the state. These models hold great promise to achieve the holistic care of persons with mental illness and other physical illnesses.

3) The emergency departments in general hospitals are suffering from the unanticipated demand to care for increasing numbers of psychiatric patients. The increase is due to three key factors: 1) reduced availability of private and state hospital psychiatric beds; 2) the Emergency Medical Treatment and Active Labor Act (EMTALA) that requires that any patient arriving at an emergency department must receive an appropriate medical screening examination. If the examination finds an emergency medical condition, the hospital is required to treat the individual until the condition stabilizes or transfer the patient to another hospital that is able to treat the patient; 3) the closing of hospitals has resulted in the national reduction of nearly 200,000 emergency beds. The result is that emergency department visits are growing faster the U.S. population.

4) A promising approach to address the dilemma of overwhelmed emergency departments is the collaborative We Care Regional Crisis Center project at Lima. The program began in 2005 and since then has dramatically reduced the number of psychiatric referrals that have been handled by hospital emergency departments.

5) Another promising study conducted by the University of South Carolina Medical Department revealed that the development of partial hospitalization programs combined with the availability of psychiatric specialties in emergency departments can impact on the number of admissions through emergency departments.

6) A multi-disciplinary psychiatric services team incorporated in an emergency department can reduce the demand on the emergency department staff, and provide more appropriate assessment and stabilization services for persons in acute psychiatric distress.

7) The PASRR data indicate a marked increase in the number of total resident reviews processed over the past five years. A likewise increase is noted in the number of denials of requests for continued stays in NFs. Most surprising and disturbing is the marked increase in the referral of younger adults to NFs.

8) The Northeast region of Ohio, and three counties in particular, account for an inordinate percentage of PASRR reviews and for an even higher percentage of PASRR denials. The data points to a growing problem in the Northeast region of Ohio of discharging psychiatric patients from private hospitals to NFs by utilizing the hospital exemption. While on a rare occasion such a discharge plan may be indicated due to the patient's medical condition, the high rate of denials suggests that this practice may be an inappropriate discharge plan on many occasions. The rationale frequently cited to justify the practice include: 1) The private psychiatric hospitals are under pressure to discharge patients no longer deemed to need inpatient care; and, 2) The community mental health system does not have sufficient resources including housing, case management and other services to serve these patients upon discharge. Thus, the private psychiatric hospitals discharge psychiatric patients without any other medical diagnosis that would require the level of services provided in an NF which is required for admission into a Medicaid-certified NF. While the practice allows the private psychiatric hospitals to free up a bed for another potential patient, and allows the mental health provider not to concern itself with discharge planning directly to the community, the practice has several inherent significant drawbacks and needs to be carefully monitored.

With the high denial rates, several concerns are raised that these patients should not have been sent to the nursing home in the first place:

- a) Many NFs may not be staffed, equipped nor organized to provide the specialized psychiatric treatment and care that psychiatric patients need; as such, no NF is license or certified by ODMH to provide behavioral healthcare.
- b) Many of the psychiatric patients are much younger and physically healthier than the rest of the nursing home population which is comprised of elderly and physically more frail patients. The mismatch of mixing these populations has lead to incidents of abuse, exploitation, and even death.
- c) Medicaid costs are already out of control and eroding a large share of federal and state coffers. Inappropriate placements provide a drain on these valuable resources. The perpetuation of inappropriate NF placement adversely affects the availability of funding that could be used to strengthen the community MH system.
- d) The potential for discontinuity of care is highly likely. With psychiatric patients being discharged to the care of NFs, the community mental health provider and ADAMH Board may not be as actively involved in the aftercare and discharge planning as is necessary. When the thirty-day hospital exemption (convalescent stay) expires, it has typically been the NF staff responsibility to then secure community placement.

e) The practice only temporarily defers the necessary discharge planning that needs to take place to assure an adequate community placement is in place to meet the discharged patients treatment and care needs.

Part VIII

Community Perception

Part VIII

Community Perception

Board Association, Provider Council, and Ohio Hospital Association Surveys

Acknowledging that the crisis in acute care is a system issue impacting on stakeholders, and also fully cognizant that the solutions to the crisis can be found with the stakeholders as well, ODMH requested direct input from the ADAMH/CMH Boards, provider agencies, and the private psychiatric hospitals. A survey was developed with input from the Ohio Council of Behavioral Healthcare Providers representing nearly all mental health agencies in the state, and the Ohio Association of County Behavioral Health Authorities presenting all county mental health and alcohol, drug addiction and mental health services board in the state. (See Appendices c and d for the survey instruments.)

The Ohio Council of Behavioral Healthcare Providers and the Ohio Association of County Behavioral Health Authorities were requested to send the survey to their membership, tabulate the results, and submit their findings to ODMH. The Ohio Council of Behavioral Healthcare Providers limited the survey to those agencies who were directly involved in the pre-screening process for inpatient hospitalization. Each survey consisted of ten questions. The questions were similar for both surveys, but varied based on the different responsibilities of the ADAMH/CMH Boards and the provider agencies.

The Ohio Hospital Association developed their own survey utilizing the basic construction of many of the questions on the Board and Provider surveys. The Ohio Hospital Association conducted their own survey and shared the results with ODMH.

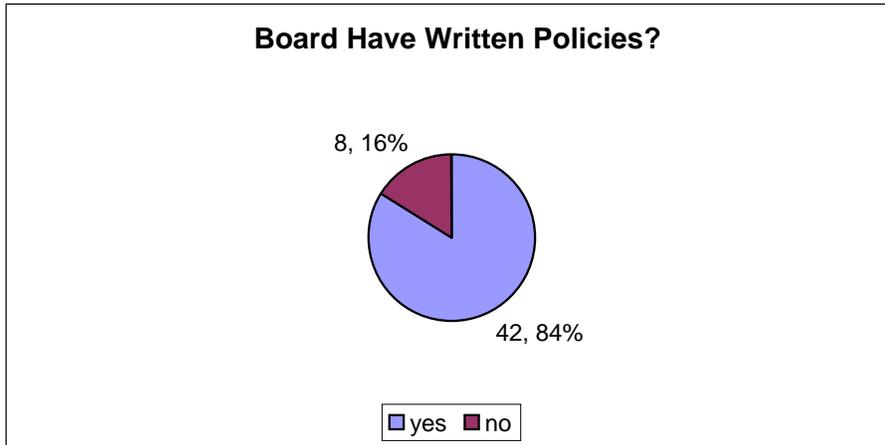
Board Survey Responses

The Ohio Association of County Behavioral Healthcare Authorities received a one hundred percent (100%) return response on the survey from their members. The survey results are presented in the following graphs.

Figure No. 89.

Question No. 1

Does the Board have written policies, procedures or guidelines to follow for psychiatric hospitalization within your system of care?

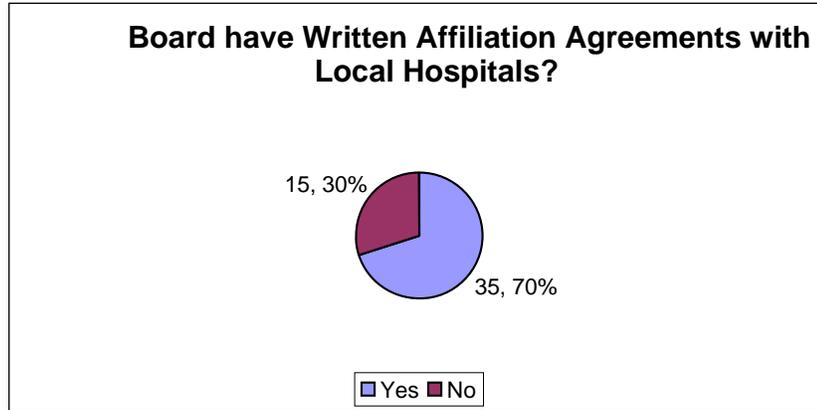


Source: TSIG Study, September, 2008

The response to question 1 indicates that 84 percent of the boards do have written policies and procedures to follow for psychiatric hospitalization within their respective system of care. A concern was that a unanimous response to this question would have been anticipated. In light of the system responsibility of the Boards, all would be anticipated to have written policies that address a critical area of their system of care, i.e. inpatient hospitalization. Given this baseline, question 2 delved further to inquire if the Board also had written affiliations or agreements with local hospitals for adult psychiatric hospitalization. See Figure No. 90 on the next page.

Figure No. 90.

Question No. 2
Does the Board have written affiliations or agreements with local hospitals for adult psychiatric hospitalization?



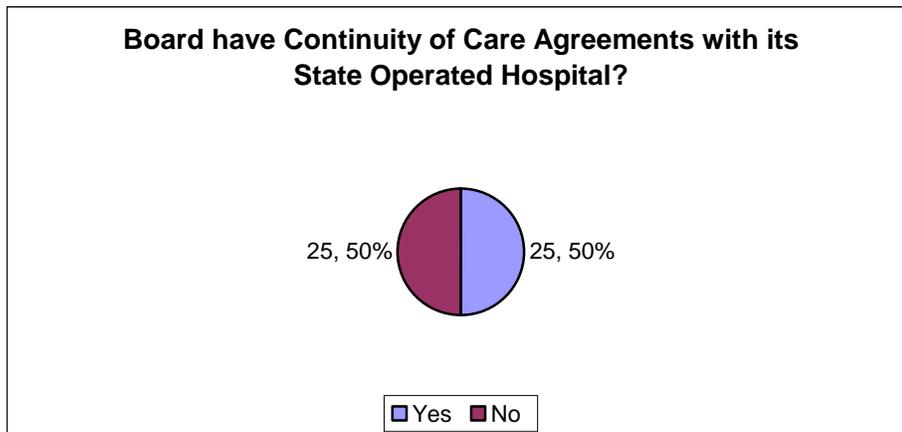
Source: TSIG Study, September, 2008

The boards' response to Question 2 revealed that a clear majority do have written affiliation agreements with local hospitals. The drop off of 14 percent or seven boards from those that have written policies and those with an affiliation agreement indicates a need for continued efforts in some board areas to establish coordinated care.

Question No. 3 looked to discover whether the Boards possess a continuity of care or other written agreement with its state operated hospital that addresses admissions, treatment, and discharge procedures, and management of patient information. See Figure No. 91.

Figure No. 91.

Question No. 3
Does the Board possess a Continuity of Care Agreement with its State Operated Hospital?



Source: TSIG Study, September, 2008

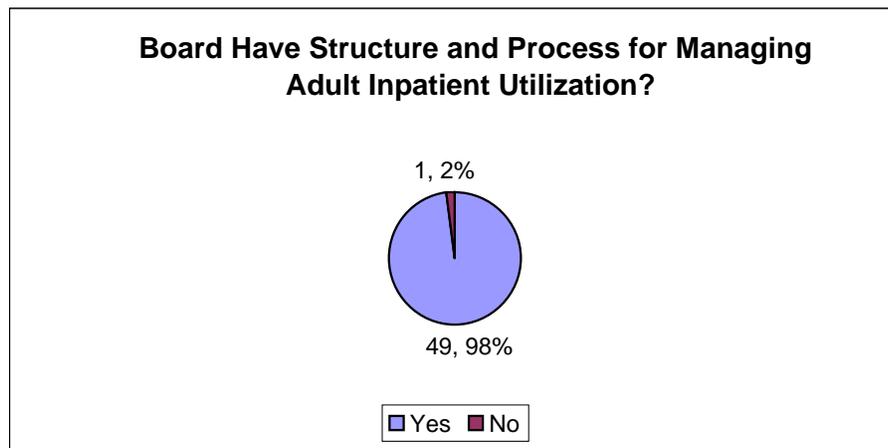
The response to question 3 reveals that only half of the Boards have a continuity of care agreement with their state hospital. A well executed continuity of care agreement that is followed by all parties can be effective in improving collaboration, reducing miscommunication, and improving patient care as patients transition in and out of hospital care. That only half of the Boards have such an agreement is clearly an area needing addressed.

The fourth question inquired whether the Boards have a structure and process for managing adult inpatient utilization. The response shown below was nearly unanimous. The response indicates that the Boards appreciate the importance of managing adult inpatient utilization from both a fiduciary and clinical perspective. See Figure No. 92.

Figure No. 92.

Question No. 4

Does the Board have a structure and process for managing adult inpatient utilization?



Source: TSIG Study, September, 2008

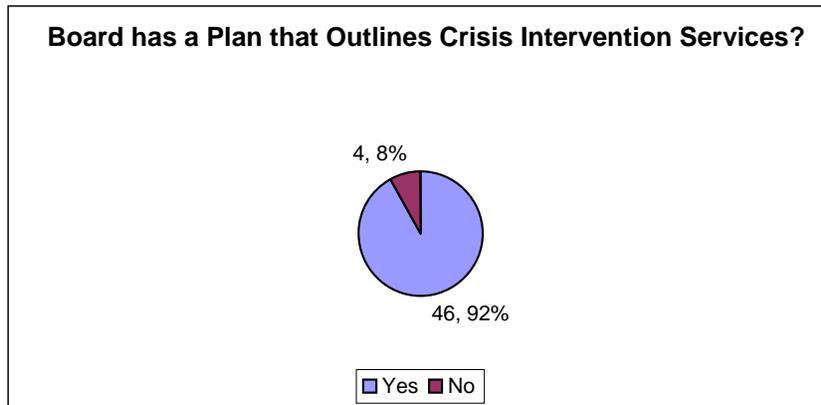
Question 5 inquired as to whether the boards have a plan that outlines crisis intervention services. As there can be some confusion as to what services comprise crisis intervention, the survey used the definition from the Ohio Administrative Code § 5122-29-0: "(A) Crisis intervention is that process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic."⁴²⁰ The response was 92 percent in the affirmative. However, as with question # 1, a unanimous response was anticipated since crisis intervention services, such as inpatient hospitalization, are a critical core service of care. See Figure No. 93 on the next page.

⁴²⁰ Ohio Administrative Code § 5122-29-0.

Figure No. 93.

Question No. 5

Does the Board have a plan that outlines crisis intervention services?



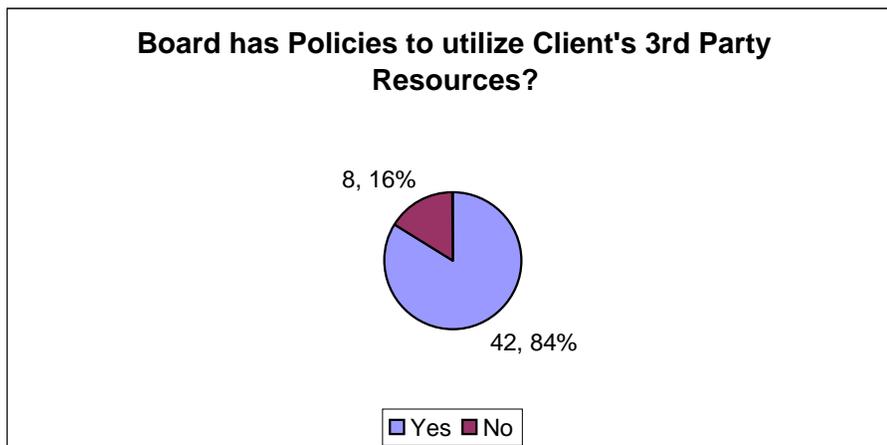
Source: TSIG Study, September, 2008

The sixth question asked about when the board's contract agencies determine that a client requires hospitalization, does the Board have policy provisions in place to utilize the client's third party payer resources? Given the finite public resources, the maximizing of available third party resources is important. The response was that 84 percent of the boards do have such a policy provisions. However a unanimous response was anticipated again. See Figure No. 94.

Figure No. 94.

Question No. 6

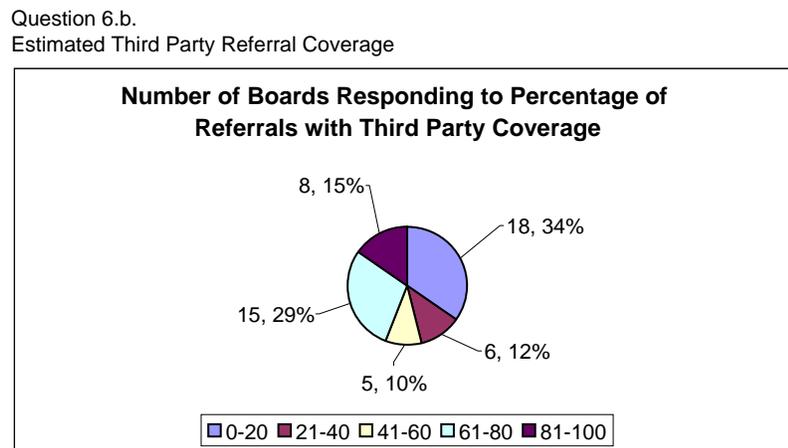
When the Board's contract agencies determine that a client requires hospitalization, does the Board have policy provisions in place to utilize the client's third party payer resources?



Source: TSIG Study, September, 2008

A follow up to question 6 asked the Boards to estimate the percentage of their private psychiatric hospital referrals that have third party coverage. See Figure No. 95.

Figure No. 95.



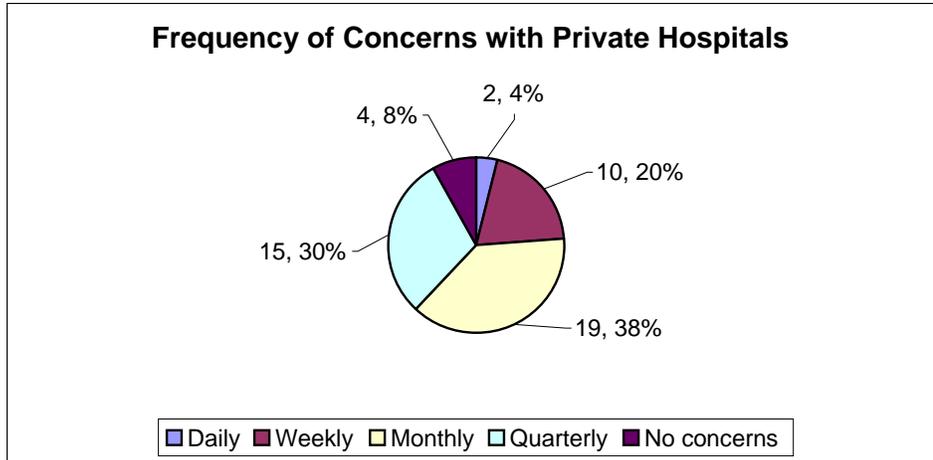
Source: TSIG Study, September, 2008

The response indicates that the highest percentage of Boards (34 percent) indicated that 20 percent or less of their referrals had third party coverage. The second highest percentage of boards (29 percent) estimated between 61 and 80 percent of the referrals had third party coverage. The results indicate that while third party coverage represents a small percentage of the referrals for nearly one-third of the Boards, for nearly two-thirds of the Boards third party coverage represents at least one out of every five referrals. Nearly half of the boards (44 percent) noted that third party coverage comprises over 60 percent of their referrals. Clearly, the Boards are increasingly involved in the hospitalization of persons who have third party payer coverage.

Question 7 was a multi-part inquiry into the Boards' experiences with the private or community hospitals in their communities. Question 7(a.) asked the Boards to identify the frequency of times they experienced issues with the private or community hospitals regarding access to adult inpatient psychiatric care in the past year. The Boards' response indicates that nearly two-thirds (62%) of the Boards experience at least monthly issues. See Figure No. 96 on the next page.

Figure No. 96.

Question No. 7 a.
Rate Frequency of having issues with private or community hospitals.

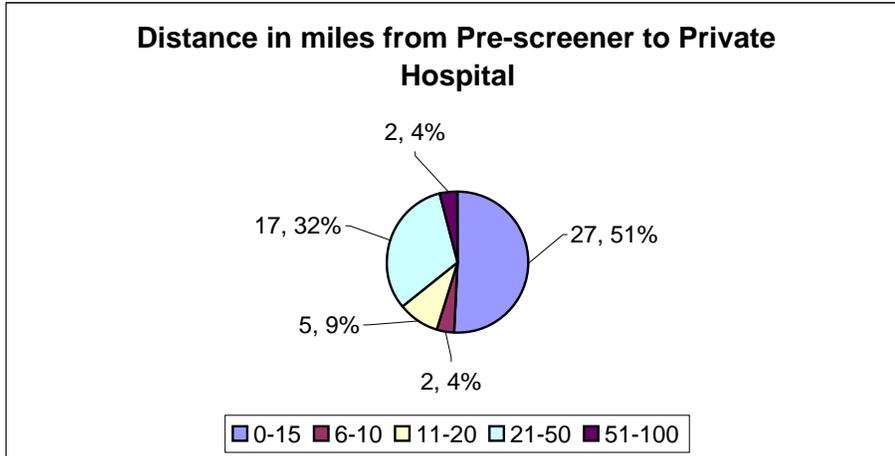


Source: TSIG Study, September, 2008

Question 7.b. inquired of the Boards, “How far from your primary pre-screening agency is the closest private psychiatric inpatient provider?” See Figure No. 97 on the following page. The Boards’ response indicates that the majority (52 percent) have a hospital within five miles of their primary pre-screening agency. Conversely, a third of the boards indicated a distance of between 21 and 50 miles. Two Boards indicated a distance in excess of 51 miles. The response indicates that while there is good geographic coverage across the state, there remains (as noted previously) areas where the distance makes access within one hour very difficult. This part of the inquiry only addressed the issue of distance. Whether or not the hospital consistently had ready capacity to receive the referral, regardless of geographic distance, is another matter altogether and one that may need further analysis.

Figure No. 97.

Question No. 7 b
How far from your primary pre-screening agency is the closest private psychiatric inpatient provider?



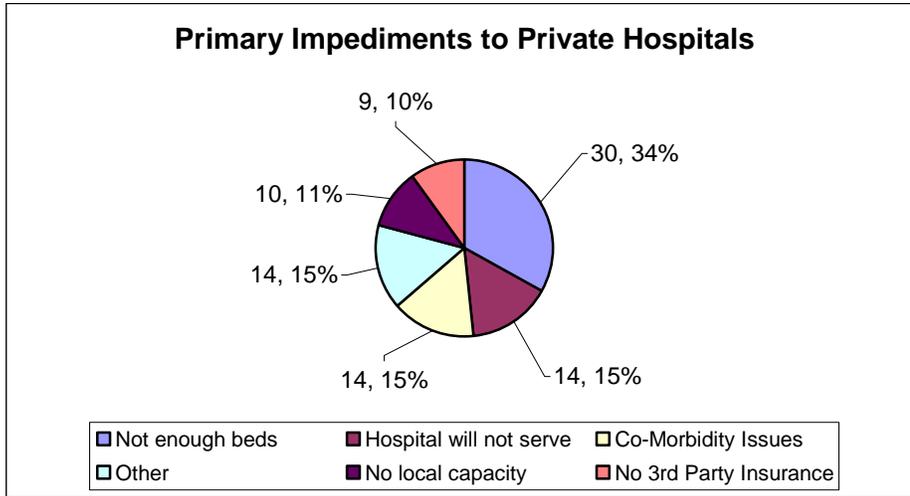
Source: TSiG Study, September, 2008

Question 7.c. of the multi-part inquiry asked the Boards to identify their primary impediments to accessing private adult inpatient psychiatric care. The results indicate that not enough beds were identified by over half of the Boards (58 percent), and not enough beds represented the highest number of any of the responses. Other issues identified frequently were the private hospital being unwilling to serve, the client characteristics or co-morbidity issues, and other impediments. No third party insurance and no local inpatient capacity impediments were less frequently identified by the boards. Note that the Boards could respond with more than one impediment. See Figure No. 98 on the following page.

Figure No. 98.

Question No. 7 c

What are the primary impediments to accessing private adult inpatient care?



Source: TSIG Study, September, 2008

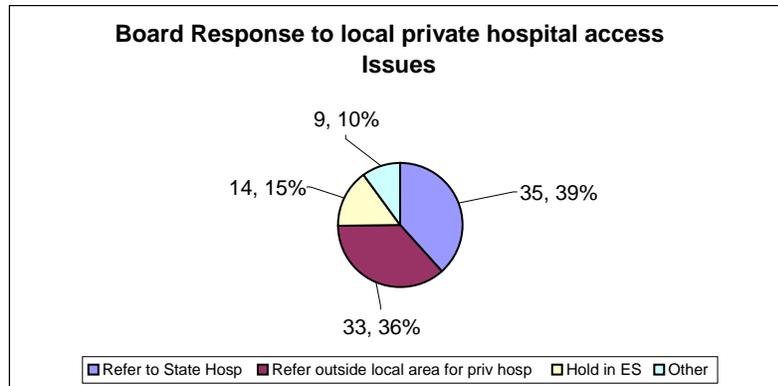
Question 7.d. of the private hospital inquiry asked the Boards “What percentage of your last twenty referrals were accepted for admission by private psychiatric hospitals?” The average response from the boards was 73.86 %.⁴²¹

Question 7.e. of the private hospital inquiry asked the Boards, “When the Board has local private access issues, what is the Board’s system response?” By far, the two most frequent responses were to either refer to the state hospital or to look outside of the Board’s local area for an available bed. The practice of holding the client over in the local emergency service was identified less often. See Figure No. 99 on the next page.

⁴²¹ Ohio Association of County Behavioral Health Authorities, TSIG Study: Access to Adult Care Board Questionnaire Response Final Report, p. 6.

Figure No. 99.

Question No. 7 e
When the Board has local private access issues, what is the Board's response?

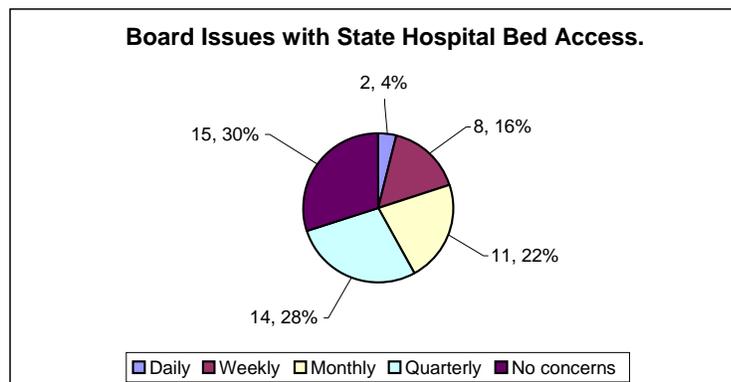


Source: TSIG Study, 2008

Question No. 8 was also a multi-part inquiry into the Boards' experiences with the state hospitals. Question 8 looked into the Boards' ability to access the state hospital beds. Question 8 (a.) asked the Boards to rate their access to state hospital beds. The Boards were asked to identify the frequency of time they experienced issues with accessing the state hospital beds. The Boards' response indicated that 44 percent of the Boards' experience at least monthly issues. In comparison, 62 percent of the Boards identified at least monthly access issues with their local community or private hospitals. The disparate number and frequency of contacts by the Board with a local private provider as opposed to the state hospital may be factor in the difference in the percentages of issues. Thirty percent of the Boards responded that they had no access concerns related to state hospital beds. See figure No. 100.

Figure No. 100.

Question No. 8 a.
Board Issues with State Hospital Bed Access.



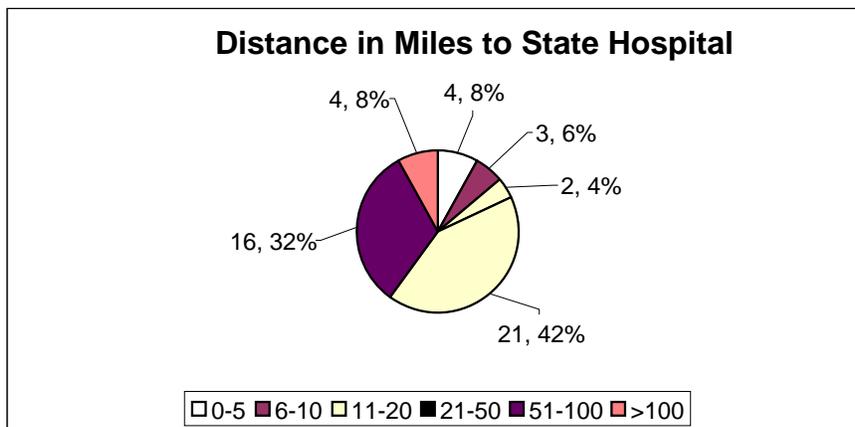
Source: TSIG Study, September, 2008

Question 8.b. inquired of the Boards how far from your primary pre-screening agency is the closest state hospital? See Figure No. 101 on the next page. The Boards' response indicates that only eight percent of the Boards have a hospital within five miles of their primary pre-screening agency. The Boards responded that 52 percent had a private or community hospital within five miles or less of their pre-screening agency. The divergent response is to be expected given the lesser number of state hospital facilities (seven state hospital sites versus eighty-two private hospitals with licensed psychiatric beds). The most frequent response from the Boards (42 percent) was that the state hospital was between twenty one and fifty miles of their primary pre-screening agency. Sixty percent of the Boards responded that a state hospital was within 50 miles of their primary pre-screening agency.

Conversely, 40 percent of the Boards noted that a state hospital was greater than fifty one miles away. Four Boards stated the state hospital was in excess of one hundred miles from their primary pre-screening agency. The response indicates that while the majority of Boards can access a state hospital within one hour of driving time on average, a large percentage (40 percent) are more than an hours drive, and a few Boards' primary pre-screening agency are more than a two hour drive from a state hospital. While the reduction in the number of state hospital facilities is a definite factor, the impact on overall system access is the critical measure, that is, does every Board have an adequate number of inpatient beds for the local need that they can access within one hour of their primary pre-screening agency?

Figure No. 101.

Question 8 b.
How far from your primary pre-screening agency is the closest state hospital?

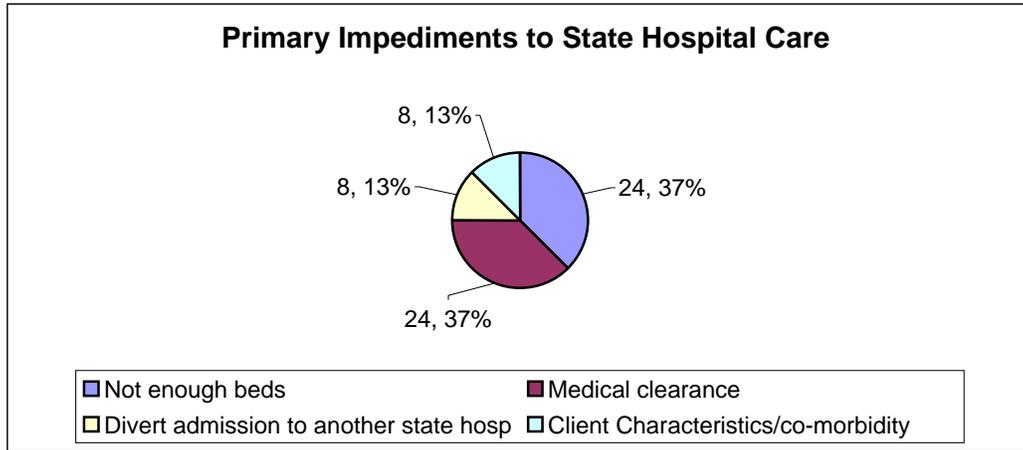


Source: TSIG Study, September, 2008

Question 8 c. asked the Boards to identify the primary impediments to accessing local state hospital care. The two most frequently cited impediments were insufficient number of beds and medical clearance issues. Diverting admissions to another state hospital and client characteristics and co-morbidity issues were less frequently cited. See Figure No. 102 on the next page.

Figure No. 102.

Question No. 8c
Primary Impediments to State Hospital Care



Source: TSIG Study, September, 2008

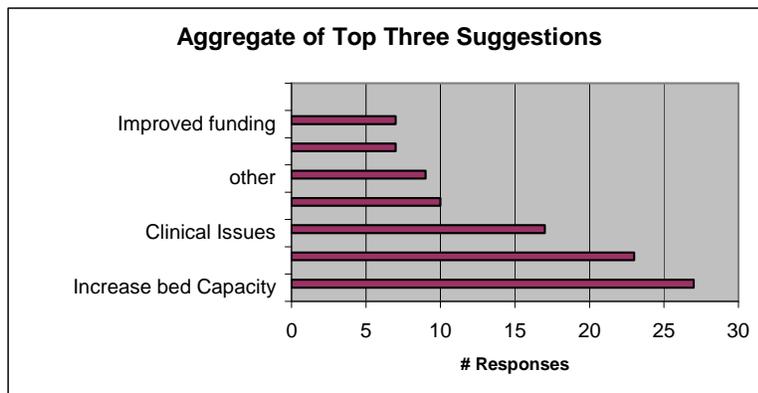
In Question No. 9, the Boards were asked to identify their top three suggestions to improve overall access to adult inpatient care and indicate whether the suggestions were directed to state hospitals, private hospitals, or both. By aggregating together the top three suggestions and placing them in similar categories of responses, the top suggestion category was in the area of increasing inpatient bed capacity followed by improving intersystem communication and clinical issues. See Figure No. 103.

Figure No. 103.

Question 9

Please identify your top three suggestions to improve overall access to adult inpatient care.

Indicate whether your suggestions are directed to state hospitals, private psychiatric hospitals or both.



Note: Most responses did not clearly indicate where the suggestion was directed.

Source: TSIG Study, September, 2008

The final question of the Boards' survey asked the Boards to comment on any issues pertinent to the topics in the survey. Those Boards that chose to respond noted a wide range of issues. The most frequently cited issue was standardizing medical clearance and other admission procedures. Other suggestions that elicited multiple responses concerned children issues, funding, quality improvement activities, intersystem communication, distance to hospitals, new clients in the system, lack of resources, and clinical/co-morbidity issues. Some of these issues may overlap.

Providers' Survey Responses

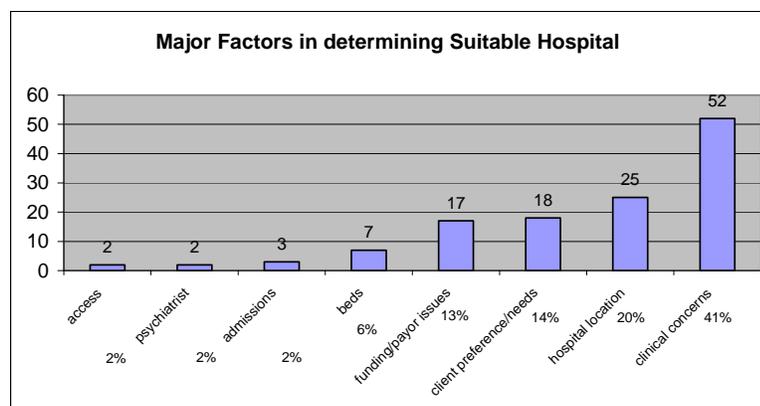
The Ohio Council of Behavioral Healthcare Providers was asked to forward the questionnaire to all of their member agencies that provide pre-screening services prior to inpatient hospitalization. The survey target population identified by the Ohio Council was 136 providers. Only 33 agencies responded for a response rate of 24 percent. Although the response rate was lower than anticipated, the responses were deemed to be fairly representative across all regions of the state as well as a cross section of large, medium and small agencies in urban, suburban and rural environments.

Question 1 of the survey asked the provider agency to answer an open ended question: During mental health crisis situations, when you assess the client's need for psychiatric hospitalization, what major factors are considered in determining the most suitable hospital provider?

Clinical concerns were the primary factor cited most frequently of all responses (41 percent), followed by hospital/location (20 percent), client's preference (14 percent), and funding/payer issues (13 percent). See Figure No. 104. As might be anticipated, the front line pre-screeners are primarily concerned with clinical issues in attempting to match the client's needs with available inpatient providers.

Figure No. 104.

Question No. 1
During mental health crisis situations, when you assess the client's need for psychiatric hospitalization, what major factors are considered in determining the most suitable hospital provider?



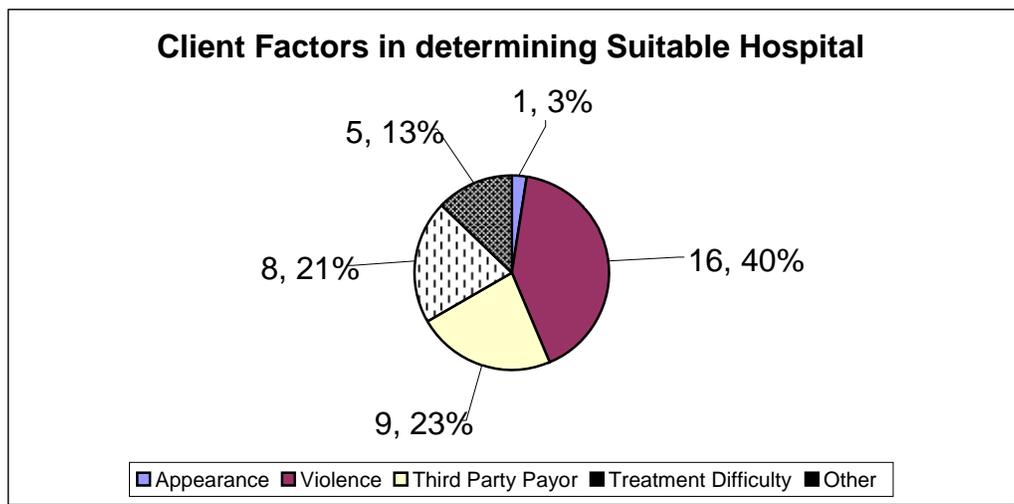
Source: TSIG Survey, September, 2008

Question 2 provided a predetermined list of potential client factors that might be used to determine the most suitable hospital provider. The pre-screening agency staff was asked to rank order their relative importance. The number of times that a factor was ranked number one was then tabulated. Violence was by far the most frequently factor cited as most important (40 percent) followed by payer source (23 percent) and treatment difficulty (21 percent). The result confirms that clinical factors, especially violent behavior are critical in the decision making process. The result also reveals that payer source is a significant factor. The results are displayed in Figure No. 105.

Figure No. 105.

Question No. 2

Of the following factors related to determining the most suitable hospital provider, please rank their relative importance from 1 to 6 with one (1) being the most important. N= number of times the factor was ranked # 1



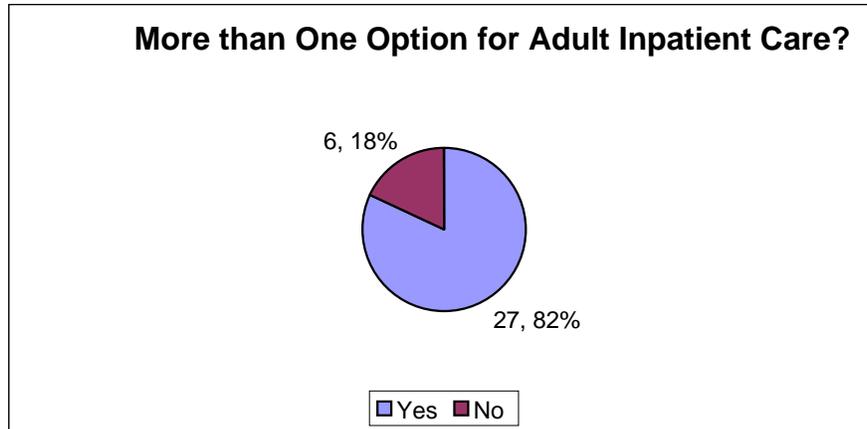
Source: TSIG Survey, September, 2008

Question 3 asked the pre-screening agency whether they typically have more than one option in referring clients for adult inpatient care. The vast majority of the responses were in the affirmative (82 percent). The result indicates that for the most part, pre-screening agencies have options available to them to decide on where to hospitalize. For the remaining eighteen percent, with only one option available, issues of bed availability, client characteristics and co-morbidity issues can be critical factors. See Figure No 106 on the next page.

Figure No. 106.

Question No. 3

Do you typically have more than one option in referring clients for adult inpatient care?



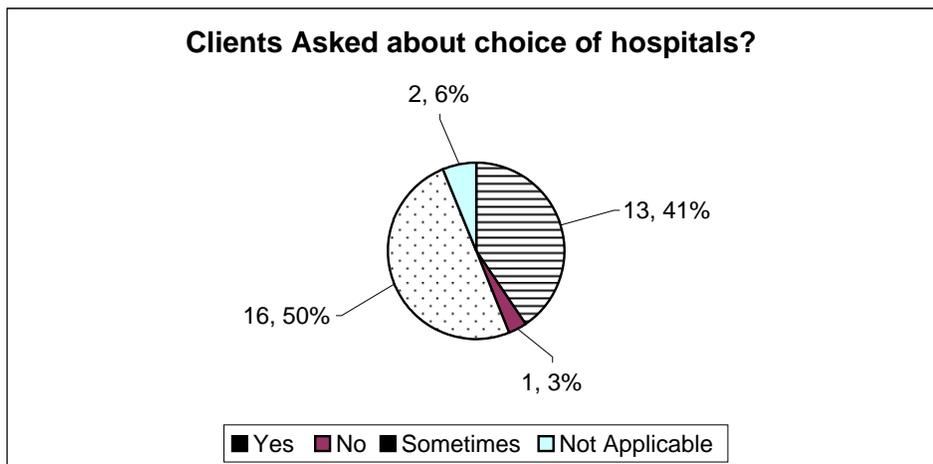
Source: TSIG Survey, September, 2008

Question 4 asked the pre-screening agencies: Are clients asked about their choice of hospitals? The most frequent response was 'Sometimes' (50 percent), followed closely by 'Yes' (41 percent). Only one response indicated that clients are not asked their choice of hospitals. The result indicates that while client's choice is not always a consideration, the client's choice is frequently contemplated. See Figure No. 107.

Figure No. 107.

Question No. 4

Are clients asked about their choice of hospitals?

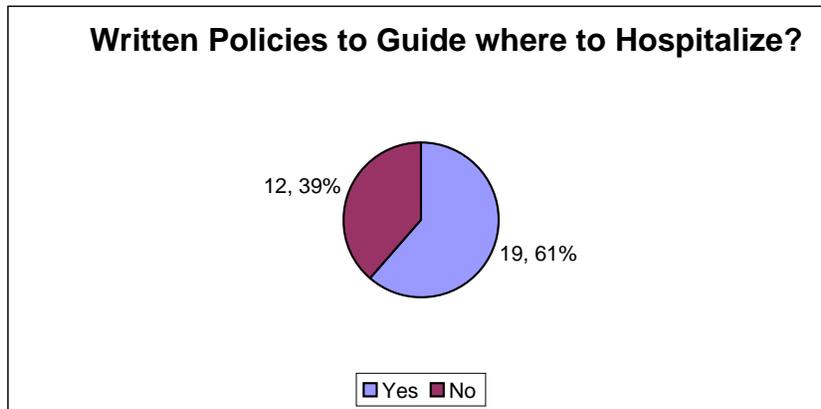


Source: TSIG Survey, September, 2008

Question 5 asked the pre-screening agencies if there are written policies, procedures or protocols in place to guide the clinician's decision-making about where to hospitalize. A slight majority responded in the affirmative (61 percent). See Figure No. 108.

Figure No. 108.

Question No. 5
Are there written agency policies, procedures, or protocols in place to guide the clinician's decision-making about where to hospitalize?

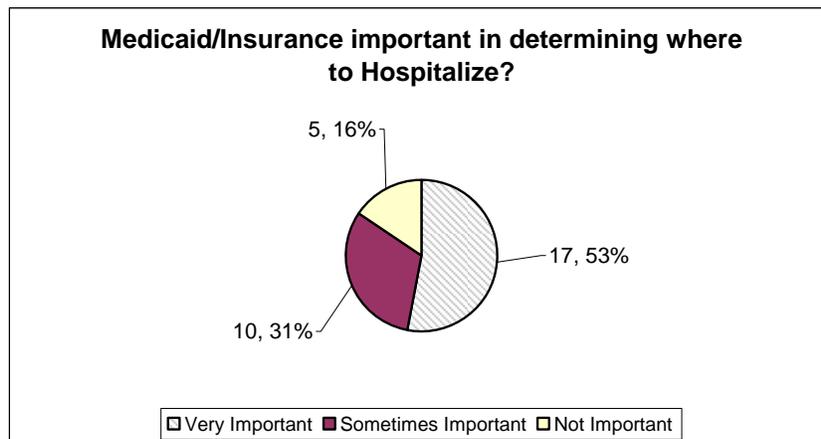


Source: TSIG Survey, September, 2008

Question 6 asked whether a client's Medicaid or other insurance coverage is important in determining where to refer for hospitalization. The response indicates that a clear majority (84 percent) consider a client's third payer coverage to be an important consideration. See figure No. 109.

Figure No. 109.

Question No. 6
Is a client's Medicaid or other insurance coverage important in determining where you refer for hospitalization?



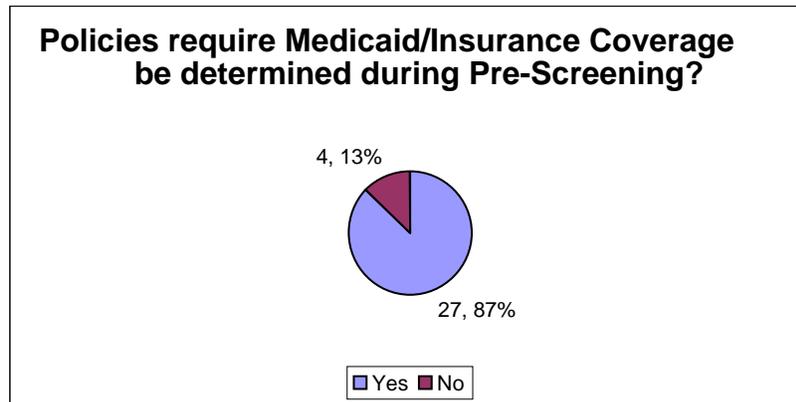
Source: TSIG Survey, September, 2008

Question 7 asked the pre-screening agencies whether there are specific agency policies, procedures, or protocols in place that require a client's Medicaid or other insurance coverage be determined during the pre-screening, intake or assessment process. The overwhelming majority confirmed that there are specific policies, procedures or protocol in place (87 percent). See figure No. 110.

Figure No. 110.

Question No. 7

Are there specific agency policies, procedures, or protocols in place that require a client's Medicaid or other insurance coverage be determined during the pre-screening, intake or assessment process?



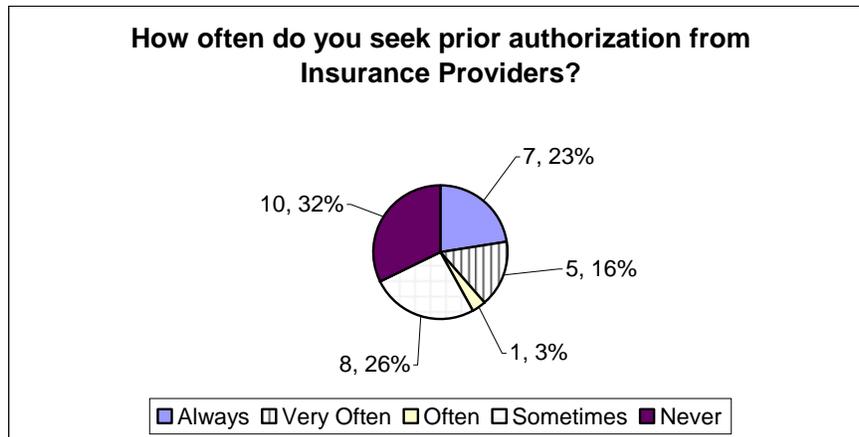
Source: T SIG Survey, September, 2008

Question 8 asked the pre-screening agencies about when working with clients who have managed insurance plans (HMO, commercial, managed Medicaid, etc.) how often the agency seeks prior authorization before referring to a hospital provider. The most frequent response was 'Never' (32 percent) followed by 'Sometimes' (26 percent). Thus, in the majority of the cases, prior authorization is not routinely sought even though it is known that the client has third party payer coverage. In only twenty-six percent of the time was the response either always or very often. See Figure No. 111 on the next page.

Figure No. 111.

Question No. 8

When working with clients who have managed insurance plans (HMO, commercial, managed Medicaid, etc.) how often do you seek prior hospitalization before referring to a hospital provider?



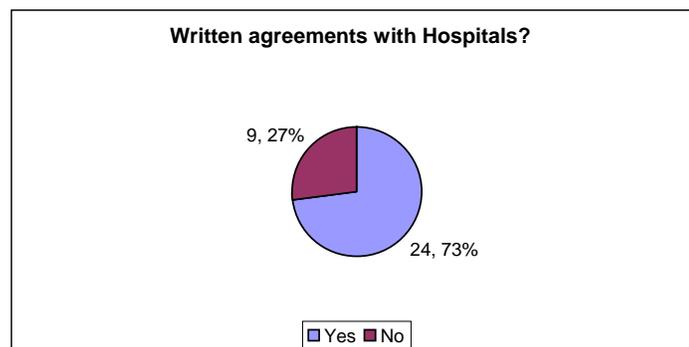
Source: TSIG Survey, September, 2008

Question 9 inquired whether the pre-screening agency had written agreements or affiliations with local private or state hospitals for adult psychiatric hospitalization. The response was in the affirmative in nearly three-quarters of the responses (73 percent). The result is encouraging that in a clear majority of the time, the agency and the hospital are operating based on a written agreement between them. See Figure No. 112.

Figure No. 112.

Question No. 9

Does your agency have written agreements or affiliations with local private or state hospitals for adult psychiatric hospitalization?



Source: TSIG Survey, September, 2008

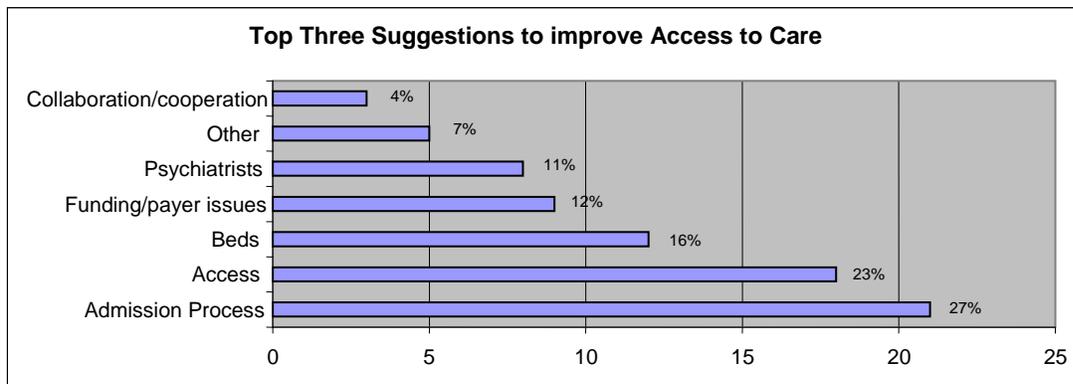
Question 10 asked the pre-screening agency to identify their top three suggestions to improve overall access to adult inpatient care and indicate whether the suggestions are

directed to state hospitals, private psychiatric hospitals, or both. Improving the admissions process was the most frequent suggestion (27 percent), followed by greater access (23 percent) and more beds (16 percent). See Figure No. 113.

Figure No. 113.

Question 10

Please identify your top three suggestions to improve overall access to adult inpatient care and indicate whether your suggestions are directed to state hospitals, private psychiatric hospitals, or both.



Source: TSIG Survey, September, 2008

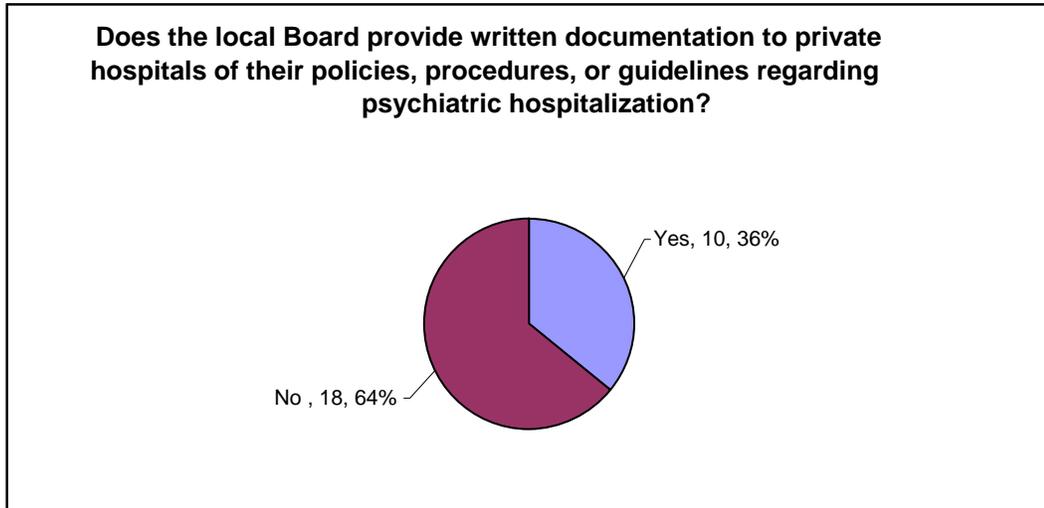
Ohio Hospital Association Survey of Private Hospitals

The Ohio Hospital Association conducted a survey of its member private psychiatric hospitals in autumn 2008. A total of 29 private psychiatric hospitals responded to the survey. The survey followed the similar line of questioning regarding acute care services that were asked of the ADAMHS Boards and the pre-screening providers. The initial question of the OHA survey asked for the title of the person completing the survey.

Question # 2 asked the respondents: “Does the local Board provide written documentation to private hospitals of their policies, procedures, or guidelines regarding psychiatric hospitalization?” The result was that nearly two-thirds of the private hospitals responded that the local Board does not share their policies, procedures or guidelines. See Figure No. 114 on the next page. The response to this question indicates there is a need for improved communication and collaboration between the private hospital providers and the local planning and funding authority, the ADAMHS Boards.

Figure No. 114.

Question # 2. Does the local Board provide written documentation to private hospitals of their policies, procedures, or guideline regarding psychiatric hospitalization?

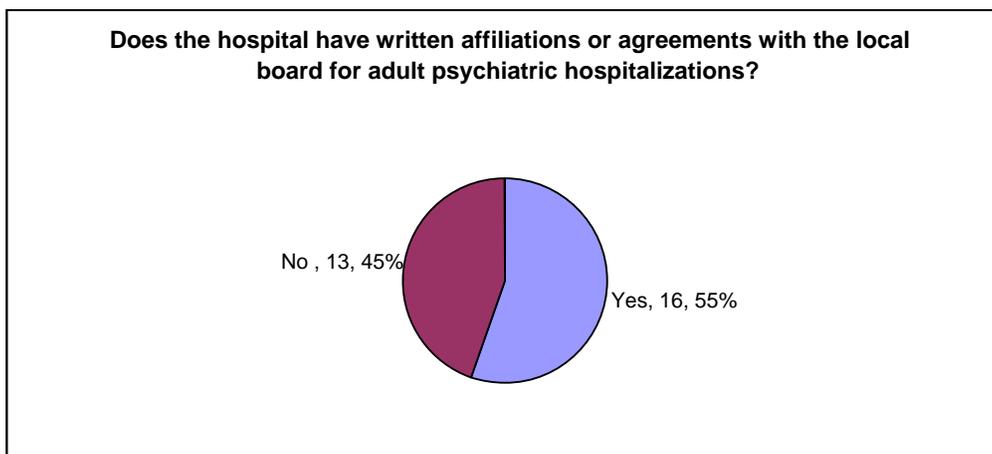


Source: Ohio Hospital Association Survey, December, 2008
Note: One respondent did not answer the question.

Question # 3 asked, "Does the hospital have written affiliations or agreements with the local board for adult psychiatric hospitalizations?" The response to this question was that a slight majority of the respondents do have written affiliations or agreements. See Figure No. 115. As with Question # 2, the result points to the need for greater communication and collaboration between the private hospital providers and the local ADAMHS Boards.

Figure No. 115.

Question # 3
Does the hospital have written affiliations or agreements with the local board for adult psychiatric hospitalizations?

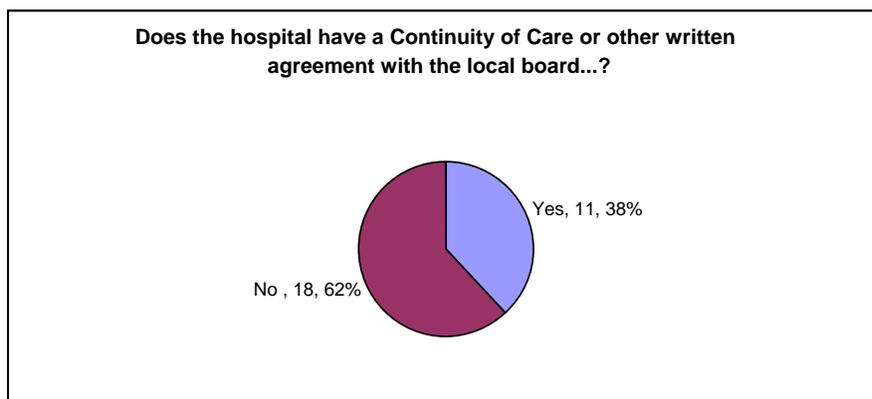


Source: OHA Survey, December, 2008

Question #4, asked the respondents: “Does the hospital have a Continuity of Care of other written agreement with the local board that addresses admissions, treatment, and discharge procedures, and management of confidential patient information?” The response was 62 percent in the negative. See Figure No. 116. As with Questions # 2 and 3, Question # 4 points to the need for greater communication and collaboration between the private inpatient providers and many of the local ADAMHS Boards.

Figure No. 116.

Question # 4
Does the hospital have a Continuity of Care or other written agreement with the local board that addresses: admissions, treatment, and discharge procedures, and management of confidential patient information?

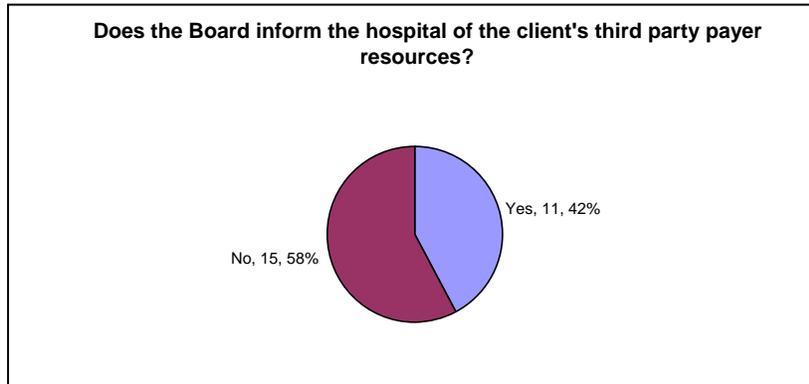


Source: OHA Survey, December, 2008

Question # 5 asked the private hospital respondents, “When the Board’s contract agencies determine that a client requires hospitalization, does the Board inform the hospital of the client’s third party payer resources?” The response was in the negative in a majority of the responses. See Figure No. 117 on the next page. While it is recognized that the pre-screening agency may not always be knowledgeable of a client’s third party payer resources, any information should be shared, even if that information is that the agency has no information.

Figure No. 117.

Question # 5
When the Board's contract agencies determine that a client requires hospitalization, does the Board inform the hospital of the client's third party payer resources?

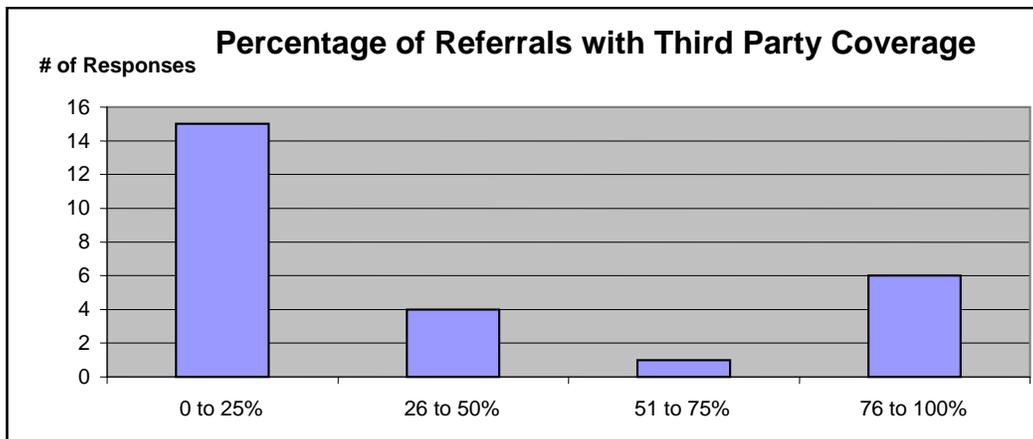


Source: OHA Survey, December, 2008
Note: Three none responses to the question.

Question # 6 asked the respondents to estimate the percentage of referrals that have third party coverage. The responses range from zero percent by two responses, to a high of 95 percent by one response. Over half the responses (58 percent) were between zero and 25 percent of the referrals having third party coverage. Conversely, only 23 percent of the responses indicated that 76 to 100 percent of the referrals have third party coverage. See Figure No. 118.

Figure No. 118.

Question # 6
Estimate the percentage of referrals that have third party coverage.



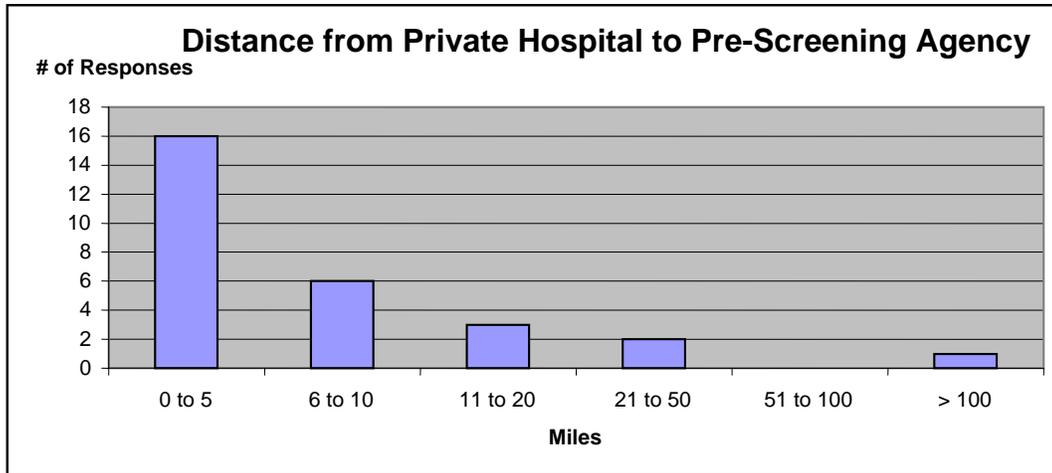
Source: OHA Survey, December, 2008
Note: Two hospitals did not respond to the question.

Question # 7 asked the respondents, "How far from your hospital is the closest pre-screening agency inpatient provider?" A majority of the responses were that the pre-

screening agency was within five miles. Over three-fourths responded that the pre-screening agency was within ten miles. At the other extreme, one respondent noted that the closest pre-screening agency was over one hundred miles from the private hospital. See Figure No. 119. The responses to this question indicate that in the vast majority of the situations, geographic distance is not a significant adverse factor to access to care.

Figure No. 119.

Question # 7
How far from your hospital is the closest pre-screening agency inpatient provider?



Source: OHA Survey, December, 2008

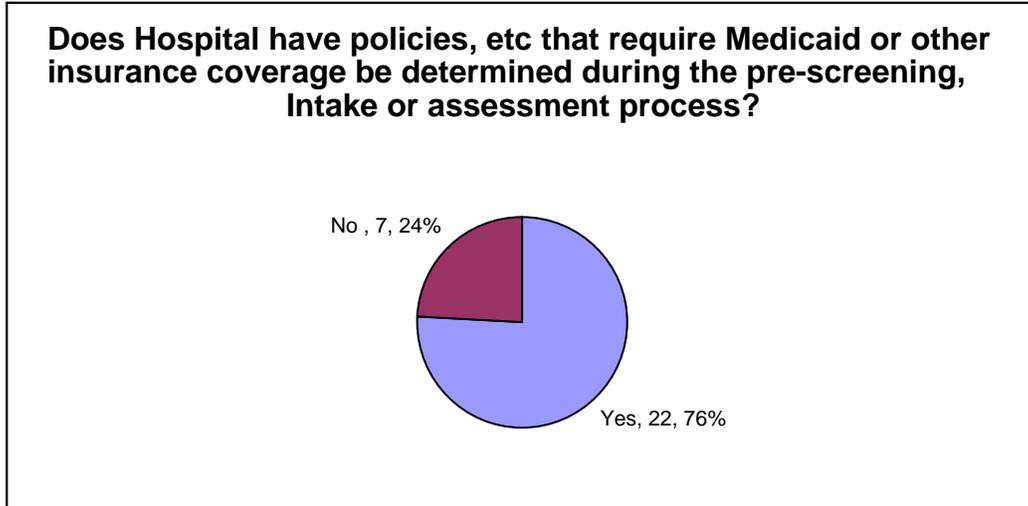
Note: There was one non response to the question.

Question # 8 queried, “Does the hospital have specific policies, procedures, or protocols in place that require a client’s Medicaid or other insurance coverage being determined during the pre-screening, intake or assessment process?” Over three-fourths of the responses were in the affirmative. See Figure No. 120 on the following page. Although this is a high positive response, the expectation is that an affirmative response to this question would have been nearly unanimous. The pertinent question for the seven hospital respondents who do not have said policies or procedures, at what point is the client’s payer status determined?

Figure No. 120.

Question # 8

Does the hospital have specific policies, procedures or protocols in place that require a client's Medicaid or other insurance coverage being determined during the pre-screening, intake or assessment process?



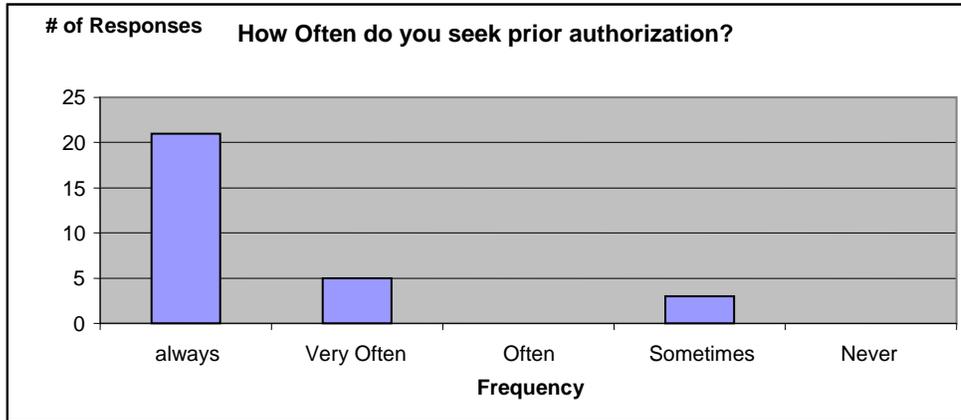
Source: OHA Survey, December, 2008

Question # 9 asked the private hospitals, “When working with clients who have managed insurance plans (HMO, commercial insurance, managed Medicaid, etc.) how often do you seek prior authorization?” Nearly three-fourths of the responses were that the private hospital always seeks pre-authorization and nearly ninety percent indicate very often or always. Ten percent of the responses indicated they sometimes seek pre-authorization. See Figure No. 121 on the next page. As expected, a high affirmative response was rendered.

Figure No. 121.

Question # 9

When working with clients who have managed insurance plans (HMO, commercial, managed Medicaid, etc.) how often do you seek prior authorization?



Source: OHA Survey, December, 2008

Question # 10 of the Ohio Hospital Association survey asked the private hospital respondents to “Please identify your top three suggestions to improve overall access to adult inpatient care (indicate whether your suggestions are directed to state hospitals, private psychiatric hospitals or both local boards).”

A total of 23 suggestions were offered. The most frequent categorized suggestions were related to medical clearance issues, utilization of available hospitals, and communication within the system.

Question # 11 asked, “On average what are your occupancy rates (relative to the capacity.) For adult beds, the average occupancy rate was 96.6 percent. For geriatric beds, 86.2 percent and for Children/Adolescents: 72.4 percent. These responses reveal that by and large the private hospitals are reporting they are nearly full especially as it pertains to adult beds. See Table No. 122.

Table No. 122.

Question # 11

On Average what are your occupancy rates (relative to the capacity)?

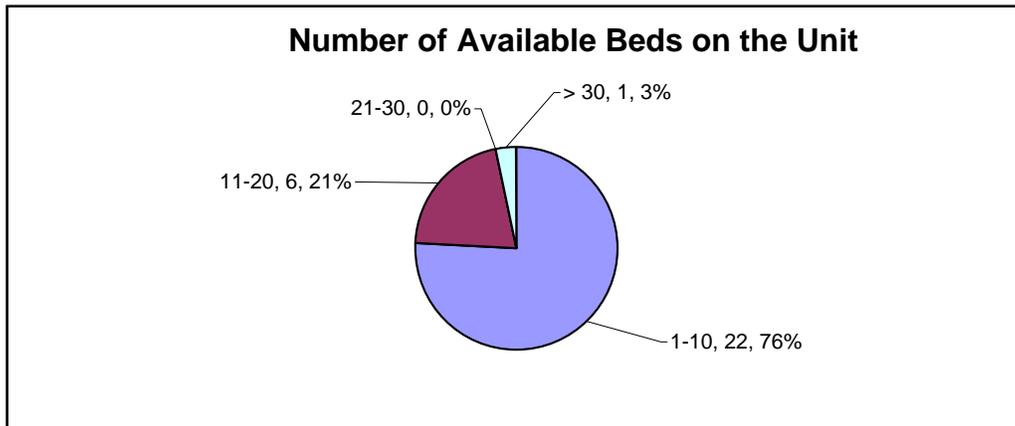
Private Hospital Occupancy Rates	Pct.	Responses
Adult	96.6%	28
Geriatric	86.2%	25
Children/Adolescents	72.4%	21

Source: OHA Survey, December, 2008

Question # 12 asked the respondents to identify the number of available beds on their units. Over three-fourths of the responses were the private hospital had ten or less beds on the unit. Another twenty-one percent indicated their units had between eleven and twenty beds; only one response indicated a unit with over thirty beds. The responses indicate that the vast majority of the private hospitals are operating small units in terms of the number of beds. See Figure No. 123.

Figure No. 123.

Question # 12
Frequency of number of available beds.

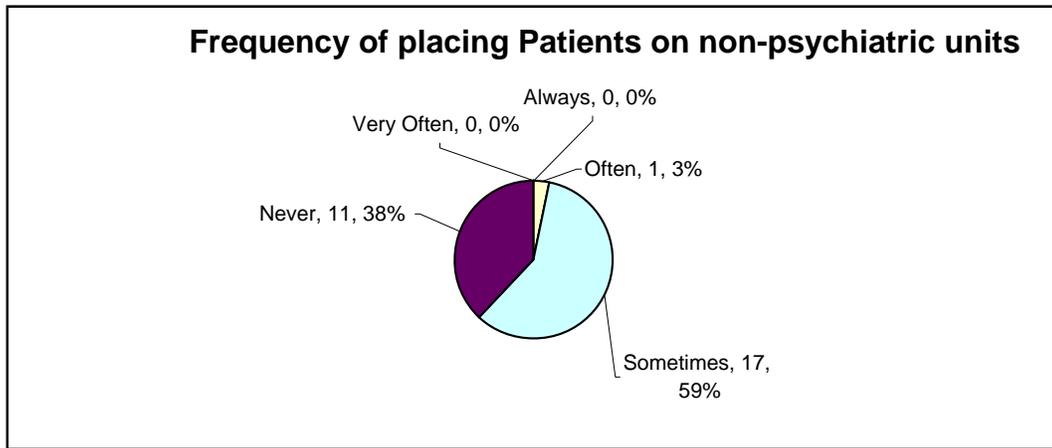


Source: OHA Survey, December, 2008

Question # 13 asked the respondents regarding the, "Frequency of placing [psychiatric] patients on non-psychiatric units." The majority response to this question was that this practice is only done sometimes or never at all. The most frequent response was that the private hospitals sometimes place patients on non-psychiatric units. Only one response indicated that their hospital often places psychiatric patients on non-psychiatric units. See Figure No. 124 on the next page.

Figure No. 124.

Question # 13
Frequency of placing patients on non-psychiatric units.



Source: OHA Survey, December, 2008

The final question was an open-ended inquiry asking the respondents to "Please comment on any issues pertinent to the topics in this survey." A total of six responses were noted ranging from clarifying the population that the hospital served to indicating that placing a psychiatric patient on another unit is considered a problem and they move the patient to the psychiatric unit within hours. Another comment noted that "there are many insurance plans that cover medical/surgical treatments in our private hospital but do not cover mental health treatment here. This is very confusing to the public." With the enactment of new state and federal mental health treatment parity laws it is hoped that there will be improved treatment options available and less confusion for the general public.

Community Perception Key Points

Board Association Survey Response Key Points

- 1) The vast majority of the ADAMHS Boards have written policies and procedures to follow regarding psychiatric hospitalization. However, as the local planning and funding entities, a unanimous response to this question would have been anticipated.
- 2) A lesser majority of the ADAMHS Boards indicated they have written affiliations with local hospitals. Again, a unanimous response to this question would have been anticipated.

- 3) Only half of the ADAMHS Boards acknowledged have a Continuity of Care Agreement with its state operated hospital. This outcome is a major concern given that a well-executed and adhered to Continuity of Care Agreement improves collaboration, communication, and overall benefit the patient's transition from community to the hospital and return to the community.
- 4) A nearly unanimous response was received from the ADAMHS Boards that they have a structure and process to manage adult inpatient hospitalizations. This response is encouraging as it points to the priority that the Boards have to manage the most expensive of all treatment options.
- 5) The vast majority of the ADAMHS Boards noted that they have a plan that outlines Crisis Intervention Services. A unanimous response would have been anticipated given that crisis intervention services are a core treatment delivery.
- 6) A significant, but not unanimous, majority of the ADAMHS Boards indicated they have policies in place to utilize a client's third party resources. In light of the finite public resources, state and local, it would be hoped that all the ADAMHS Boards would have policies to assure third party resources are utilized.
- 7) When asked to estimate the percentage of referrals for inpatient care that have third party coverage, the majority of the Boards indicated that eighty percent or less of their referrals had said coverage. The highest percentage estimated less than twenty percent of its referrals had third party coverage.
- 8) The ADAMH Boards' response indicates that the majority have at least monthly access to care issues with the private hospital providers. As discussed previously, the access issues are primarily related to the inadequate number of beds. Other issues cited include the private hospitals being unwilling to treat the prospective patient due to behavioral characteristics, co-morbidity issues, or other impediments.
- 9) A majority of the Boards indicate they have a private hospital provider within five miles of their primary pre-screening agency. The response indicates that while overall geographic coverage allows for inpatient access within one hour, there do remain pockets in the state (especially the southern central and eastern tier along the Ohio River) where access within one hour average driving time is not possible.
- 10) The Boards acknowledged that overall nearly three-fourths of their referrals to private psychiatric hospitals are accepted for admission. The dilemma is the remaining one-fourth that becomes a significant issue for the local system to address. The most common response cited by the Board is to refer the patient to the state hospital or look outside its local area for another private hospital that may be willing to accept the patient.
- 11) The ADAMHS Boards noted that forty-four percent have at least monthly access to care with their state hospital. This response is lower than the sixty-two percent response

regarding private psychiatric hospitals. Part of the reason for the discrepancy may be the ADAMHS Boards are more frequently in contact with the private hospital providers than the state hospital. The Boards cited medical clearance and not enough beds as the two primary access to care issues with the state hospitals.

12) The Boards noted that geographic access to the state hospitals is more of a problem than access to the private hospitals. This response is to be anticipated given there are now only seven hospital campuses across the state. Nearly half the Boards indicated that the state hospital is located 25 to 50 miles from their primary pre-screening agency, which roughly translates it into a drive time of between a half hour and an hour. Nearly a third of the Boards indicated that the state hospital was between 51 and 100 miles from their pre-screening agency. These distances generally correlate to a drive time of between one to two hours.

13) When asked to provide three suggestions to improve overall access to adult inpatient care, the most frequently cited recommendations were increase the number of beds in the system, improve intersystem communication and better address clinical issues, primarily medical clearance.

14) When asked to comment on any issues pertinent to the topics in the survey, the most frequently cited issue was standardizing medical clearance and other admission procedures. Clearly, standardizing the definition, requirements, and process of medical clearance is a key issue for the ADAMHS Boards. Standardization of other aspects of the admission process and procedures would be beneficial to reduce the frustration that is all too frequently encountered. The frustration is especially pronounced when the Board and provider have to look beyond their local providers for a bed. Other suggestions that elicited multiple responses concerned children issues, funding, quality improvement activities, intersystem communication, distance to hospitals, new clients in the system, lack of resources, and clinical/co-morbidity issues. Some of these issues may overlap

Pre-Screening Agency Providers' Survey Response Key Points

1) The pre-screening agency providers who responded, to the survey forwarded to them through the Ohio Council of Behavioral Healthcare Providers, identified clinical concerns as the major factor in determining the suitable hospital. Other factors frequently listed in the open ended question were the location of the hospital, client's preference and funding/payer issues. Somewhat surprising, the need for psychiatric beds was only cited six percent of the time.

2) When the pre-screening agency providers were furnished a list of client factors that might impact on determining the suitable factor, a client's violent behavior was the most frequently cited factor. Other frequently identified factors were payer issues and treatment difficulty.

3) The vast majority of the pre-screening agencies indicated that they have more than one option available to them in determining where to hospitalize a client. For the eighteen percent who responded they had only one option, as could be anticipated bed availability, client characteristics and co-morbidity issues were significant factors.

4) The Pre-screening agency providers' response indicates that half of them ask the client their preference of hospital only occasionally. A large percentage did indicate in the affirmative to the question of client's choice. Only one pre-screening provider indicated they did not ask the client's choice at all. The result indicates that client choice is taken usually into consideration in a clear majority of the agencies.

5) The majority of the pre-screening agencies note that they have written agency policies, procedures or protocols to guide decision making on where to hospitalize a client. Unfortunately, nearly four out of ten acknowledged they do not have written agency procedures. In light that all of the respondents conduct pre-screening activities, a unanimous response to this question would have been anticipated.

6) The vast majority of the pre-screening agencies acknowledge that a client's Medicaid or other insurance coverage is either sometimes important or very important in determining where to hospitalize a client. The remaining pre-screening responses indicated Medicaid or other insurance coverage was not important.

7) The vast majority of the pre-screening agencies indicated that there are agency policies and procedures in place that call for a client's third party payment coverage to be determined during the pre-screening process. However, when asked how often does the agency seek pre-authorization before referring to a hospital provider, 'never' was cited in nearly a third of the responses and only 'sometimes' in over a quarter of the responses. Thus, in the majority of the responses, pre-authorization is sought either never or only sometimes. In just under a quarter of the responses was 'always' cited.

8) Nearly three-quarters of the pre-screening providers indicated that they have in place written agreements or affiliations with private psychiatric hospitals or the state hospital. The agreements may be under the umbrella of the Board's or the agencies alone. The response is encouraging, but a near unanimous response would have been anticipated in light of the significant mutual relationship and interdependency that is in play between the hospitals and the pre-screening agency.

9) When the pre-screening agencies were asked to identify suggestions to improve the overall access to adult inpatient care, the most frequently cited suggestions were: the admission process, access issues, and beds.

Ohio Hospital Association Survey Response Key Points

1) The private hospital providers who responded to the survey indicated that only one-third of them had received the ADAMHS Boards written policies or procedures regarding inpatient hospitalization. While there is no specific requirement to do so, in the interest

of collaboration and improve communication, the sharing of policies and procedures can allow for greater continuity of care. Clearly, the sharing of policies and procedures is an area that could use improvement. In many areas, Boards have developed written agreements with the local private hospitals. This document could include the Board's written policies and procedures regarding inpatient hospitalization.

2) A slight majority of the private hospital providers indicated that they had a written affiliation or agreement with the local ADAMHS Boards. The same benefit mentioned in # 1 above can be derived from the mutual development and adherence to such a document. Again, the development of written affiliation agreements is an area that could use improvement.

3) The private hospitals' response to the question regarding whether their hospital has a Continuity of Care or other written agreement with the local board that addresses admissions, treatment, and discharge procedures, and management of confidential patient information, received a negative response the majority of the time. This response is again indicative of a glaring need for greater communication and collaboration between the private hospitals and the ADAMHS Boards.

4) The private hospital response indicates the clear majority do not receive information from the Board's contract agencies regarding a client's third party payer resources at the time the client requires hospitalization. However, the providers' survey response to a similar question indicated that the vast majority of the pre-screening agencies indicated that there are agency policies and procedures in place that call for a client's third party payment coverage to be determined during the pre-screening process. When asked how often does the agency seek pre-authorization before referring to a hospital provider, 'never' was cited in nearly a third of the responses and only 'sometimes' in over a quarter of the responses. Clearly, this apparent miscommunication needs addressed.

5) A clear majority of the private hospital providers estimated that less than one-fourth of the patients referred to them had third party coverage. The response is fairly consistent with the response from the Boards where the highest percentage estimated less than twenty percent of their referrals had third party coverage. This response presents a conundrum. The Ohio Hospital Association's Mental Illness by Payer Table from 2004 to 2007 indicates that no more than 10.8 percent of the cases had a payer source that was classified as self-pay, Charity Uncompensated, Bad Debt Uncompensated, or Invalid/Unknown.⁴²² Accordingly, we would have anticipated a far higher percentage of clients being identified by the respondents to the survey. Possibly, the respondents were not considering Medicare and Medicaid and similar government programs as third party payer coverage.

6) A majority of the private hospital respondents indicated that had a pre-screening agency within five miles of their location. Over three-fourths indicated the pre-screening

⁴²² Ohio Hospital Association, *MI by Payer Table*, 8/25/2008.

agency was within ten miles. The response is consistent with the Board's response to a similar inquiry.

7) The private hospital respondents overwhelmingly noted that their hospital has policies, procedures, or protocols in place that require a client' Medicaid or other insurance coverage being determined during the pre-screening, intake or assessment process. While this response is encouraging, a unanimous response would have been anticipated.

8) The vast majority of the private insurance respondents indicated that they seek prior authorization during the admission process in the case of patients who have managed insurance plans. The high affirmative response would be anticipated and nearly ninety percent indicate very often or always.

9) When asked to offer suggestions to improve the inpatient care system, a wide range of suggestions were posited. The more common themes related to related to medical clearance issues, better utilization of available hospitals, and improved communication within the system.

10) The private hospital respondents reported that on average they have nearly a 97 percent occupancy rate. The very high occupancy rate means that available beds will be a premium. A key reason for this is the vast majority of the respondents indicated that their units had 10 or less beds. The low number of beds available helps promote the high occupancy rate. From the hospital administration's perspective, this result is likely highly desirable. However, from the overall mental health system perspective, what this means is that access to private hospital beds is a significant problem. On any given day, there are likely to be simply not enough private hospital beds available to meet the demand of those needing admission.

11) The majority of the private hospital respondents indicated that they never or only sometimes will place a psychiatric patient on a non-psychiatric unit at the hospital when the psychiatric unit is full. The response indicates that when the psychiatric units are full, moving patients to another bed in the hospital to make room for new admissions is not a common practice by any means. Rather, it appears that when the psychiatric unit is deemed full, admissions are generally shut off for the duration of that occupancy status. There may be clinical, risk management, legal, accreditation, or administration factors that come into play with this decision. At the same time, the fact that a majority of the hospitals sometimes place psychiatric patients on non-psychiatric units would seem to indicate that these hospitals have worked through any barriers to the practice. The placement of carefully screened and monitored psychiatric patients on other units in the hospital may be a way to improve access to acute care beds as well as assist the psychiatric unit's fiscal bottom line.

Part IX

Themes with Further Considerations

Part IX

Themes with Further Considerations

The 2004 Report concluded with a clarion call to “Educate, Collaborate and Advocate.” The report asserted, “An increase understanding of the link between mental health and physical health is vital. As this report demonstrates, stress on the acute mental health care system permeates other systems in Ohio. The strain on consumers, families, public/private psychiatric care facilities, and alternative services is undeniable.”⁴²³ The report declared that to adequately address the crisis in acute mental health care there is a need for “An improved understanding of the relationship between mental health and physical health on the quality of life of consumers served” as well as “collaboration between public and private mental health systems to ensure quality and appropriateness of mental health services.”⁴²⁴ The report offered that a “broader, system-of-care approach is necessary to understand the issues that are affecting acute care capacity in both the public and private mental health delivery systems.”⁴²⁵

The 2004 Report identified that six years previously, Collaboratives had been established to address “issues arising from the settlement of the mental health funding lawsuit.” The Collaboratives were primarily developed around the state hospital sites known at the time as Behavioral Healthcare Organizations (BHOs). The intent of the Collaboratives was to “provide a forum for discussion of BHO and community issues, as well as other common mental health concerns.”⁴²⁶

The 2004 Report cautioned that a glaring weakness of the concept was the conspicuous absence of representatives from the private hospitals. Additionally, the 2004 identified the necessity to improve acute care data collection and sharing among an expanded membership in the Collaboratives.

The 2004 Report finally recommended the “enactment of mental health transformation driven by stakeholders in the mental health community using their individual and organizational strengths.”⁴²⁷

In its closing, the 2004 Report offered several action bullets that were recommended to respond to the challenge to “Educate, Collaborate, and Advocate.” These bullets included: Educate: Distribute this (2004) report widely, discuss with shareholders, assimilate, and share with others; Collaborate: work with natural partners and with others who are impacted, and “Identify strategies for improving and transforming the system;” and, Advocate: “Bring awareness and recommendations to decisions makers

⁴²³ ODMH, *The Crisis in Ohio’s Acute Mental Health Care Report*, 2004. p. 21.

⁴²⁴ Ibid.

⁴²⁵ Ibid.

⁴²⁶ Ibid.

⁴²⁷ Ibid.

to improve the acute care crisis as well as “advocate on individual factors that are impacting acute care.”⁴²⁸

Six years later, this updated report has highlighted the present state of acute psychiatric inpatient care in Ohio. The recommendations provided in the 2004 report remain useful in 2010. While recognizing the continuing validity of the recommendations in the 2004 Report, in 2011 and beyond there is a need to expand our understandings and future actions based on the economic considerations and the potential impact of national health care reform.

The 2010 updated report has highlighted changes in the acute care mental health system. The report has also provided a snapshot of the present state of the system in 2008-2010. This updated report has highlighted several overall ‘Themes.’ These themes will be delineated below and followed with practical considerations to address the theme issues. The considerations may seem to overlap across themes and, indeed at times, that is exactly the intent. The considerations are not meant to be an exhaustive list but rather a list of actions that may be implemented to bring about improvement to Ohio’s acute care mental health system.

Themes

A. Access to Acute Care Beds

Access to Acute Care Beds is a complex issue. However, breaking it down to its most common denominator, the main concern is the inadequate number of inpatient beds in Ohio’s overall mental health system (both public and private). There is variance across regions pertaining to the adequate number of inpatient beds. The Central and Southeast areas of the state are in need of more psychiatric beds. The number of state hospital beds in the system will barely meet the anticipated need over the next four years, and the loss of private hospital beds remains a problem. The mental health system can ill afford to lose more beds.

Considerations

1) Consider a feasibility study to explore the development of additional board/provider operated 16 bed non-IMD units across the state in areas currently thirty miles or more from a psychiatric inpatient facility. The specific geographic areas would be the south central and eastern tier along the Ohio River and the west central area of the state bordering with Indiana. Also, conduct a feasibility study to explore the development of non-IMDs in other areas of the state where the demand for beds typically exceeds the capacity.

2) Additionally, consider developing Regional 24/7 Crisis Centers across the state to serve multi-counties and multi-boards so that every Ohioan is within ready access (30

⁴²⁸ Ibid.

miles or 45 minute driving time) of a 24/7 crisis center. Regional, multi-board crisis centers are typically more cost efficient and less expensive than inpatient beds.

3) Consider alternatives to inpatient care for longer term forensic patients who meet clinical criteria for lesser restrictive setting and programming than traditional inpatient unit. This consideration will “free up” access to existing state hospital beds.

4) More clearly define the mission of state operated psychiatric hospitals within the context of an expanded inpatient service mix including: general hospitals with psychiatric units, board/provider operated Non-Institution for Mental Disease (IMD) facilities, and other types of inpatient psychiatric facilities. Within this service mix continuum, the state psychiatric hospitals’ service niche may include clients who meet one or more of the following criteria: forensic status, indigent, violence towards self or others, repeated hospitalizations, refractory to treatment, and persistent out-patient non-compliance. As part of the clearer definition, develop an Inpatient Hospitalization Decision Tree to guide admitting decisions to state operated psychiatric hospitals and other inpatient providers.

5) Streamline and standardize transfer criteria and process between other inpatient providers and state psychiatric hospitals.

6) Provide regional flexibility for access to inpatient care consistent with standards of care and the inpatient service continuum.

7) Develop licensure standards and incentives to require all other psychiatric facilities to develop observation beds for less than twenty-four hour stay to more effectively determine the continued need for treatment.

8) Develop partial hospitalization programs in concert with psychiatric expertise and other best practices at targeted emergency departments.

B. Medical Clearance

The Boards, Providers and Private Hospitals all spoke to the need for greater standardization regarding medical clearance; standardization in the definition, the requirements and the process. The issue of medical clearance is also a key matter for the emergency departments who often find themselves in the middle between the pre-screening agency who is trying to get the patient through the admission process and the receiving hospital who wants to make sure they are assuming a case that they can manage from a medical standpoint.

In response to ADAMH/CMH Board and provider concerns, ODMH recently approved (July 14, 2009) a standardized medical clearance policy for use by all state hospitals under the ODMH Medical Director’s leadership.

C. Growing Forensic Status Inpatient Population

The growing forensic status population is forecast to continue to gradually assume a greater share of the state hospital bed capacity. Of special concern is the growth in the forensic status' that typically have the longer length of stays.

Considerations

- 1) Consider alternatives to inpatient care for longer term forensic patients who meet clinical criteria for lesser restrictive setting and programming than traditional inpatient unit.
- 2) Continue to develop best treatment and educational practices that will impact on how long term patients are hospitalized while being restored to competency to stand trial.
- 3) Consider working with the criminal court system to provide innovative ways of maintaining a client's restored competency without the need for continued inpatient hospitalization.
- 4) Evaluate the Forensic Review Team (FRT) process to assure standardization across the regional psychiatric hospitals.
- 5) Consider the involvement of community boards/providers on the FRT as part of the review team. Where Boards have forensic liaisons, these positions can be involved in the review process.
- 6) Consider the expansion and standardization of the Mental Health courts to all major metro areas and regionally in rural areas.
- 7) Consider developing diversion alternatives to hospitalization for clients requiring competency restoration services who have non-violent misdemeanor or lower level felonies.

D. Fiscal Issues/Mental Health Funding

Ohio and the nation are facing extremely tough economic times. The recession is directly impacting on the state's mental health system. While a 'hunker down' mentality may be appropriate, and the primary focus is on providing the core services to the state's most vulnerable mentally ill populations, initiatives must be taken to secure improved funding. The mental health system can ill afford the loss of any more private psychiatric hospital beds.

Considerations

- 1) Consider petitioning the federal government to repeal or alter the IMD exclusion from 16 or fewer beds to 24 or fewer beds.

- 2) Consider incentives for Boards and community providers that develop best practices that demonstrate improved quality of life and reduced inpatient recidivism.
- 3) Consider a review of the existing Medicaid inpatient hospital payment structure in the context of the psychiatric acute care issues identified in this report.
- 4) Evaluate the status of Ohio's Disproportionate Share (DSH) and develop interventions to achieve a greater share along the lines of the border states of Pennsylvania and Michigan.
- 5) Explore possible changes to the Diagnostic Related Group (DRG) payment system that may allow for greater reimbursement including:
 - Adjust the Medicaid psychiatric Diagnostic Related Groups (DRG) to include severity indices.
 - Adopt Centers for Medicare and Medicaid Services Inpatient Psychiatric Facilities PPS System, RY 2009 calculator tool and worksheets for Medicare for use in calculating Medicaid payments.
 - Evaluate the use of median instead of mean length of stay in the Diagnostic Related Group structure development.
 - Adjust day high trim to be based on one standard deviation rather than present two standard deviations, and thereby encourage private psychiatric hospitals to keep and treat rather than transfer to state operated psychiatric hospitals.
 - Equalize Diagnostic Related Group relative weight for major psychiatric disorders, i.e. psychoses, other mental disorders, and disorders of personality and impulse control.
- 6) Increase Medicaid revenue with the use of Disproportionate Share for Hospitals dollars to develop non-IMD units.
- 7) Recalculate and increase funding formula for ADAMHS boards that host state operated psychiatric hospitals in their counties.
- 8) Calculate a funding formula for ADAMH Boards that are responsible for the care of persons new to the state system of care.
- 9) Develop performance based merit incentives for inpatient facilities that achieve outcome driven criteria.
- 10) Follow the lead of managed care entities in restructuring prescription costs based on the development of drug formularies that are based on objective analysis of clinical efficacy, safety and cost.
- 11) Conduct a feasibility study to determine whether a transformation in the payment structure for Inpatient Medicaid services could be of long term benefit to the mental health system.

- 12) Develop community plan guidelines that Boards must require pre-screening providers to have policy provisions in place to utilize a client's third-party payer resources when clinically indicated.

E. Greater Collaboration needed within the Mental Health System

The report has highlighted numerous examples of the need for greater collaboration and communication within the mental health system. The 2004 report referenced this need and six years later this objective remains an area in need of concerted and sustained activity. To help achieve these objectives the following considerations may provide the basic framework for improved communication and collaboration.

Considerations

- 1) Encourage ADAMHS Boards, that have yet to do so, to negotiate agreements with other inpatient providers to receive overflow diversion when the state hospitals are at capacity.
- 2) ADAMH Boards and community providers are held accountable to the expectation that clients discharged from any inpatient provider are not to be referred to Intermediate Care Nursing Facilities (ICF) unless strict medical PASRR criteria are met.
- 3) Implement collaboration between the public and private mental health systems by establishing local/regional planning groups that encourage participation of ADAMH Boards and ODMH/state hospital involvement in continuing quality improvement activities and problem solving as well as local/regional resource development.
- 4) Consider incentives for the development of regional crisis intervention and stabilization programs.
- 5) Consider incentives to encourage further collaboration among parties in the mental health system with the emphasis on improved service delivery in crisis and/or acute inpatient care programs.
- 6) Provide incentives for boards/community providers to meet the treatment expectation of a mental health treatment appointment within fourteen days and doctor appointment within thirty days following a patient's discharge from a psychiatric hospital.
- 7) Consider a statewide forum on trauma and effective treatment modalities for inpatient psychiatric services through the life span.
- 8) Implement Ohio's Transformation Incentive State Grant recommendations for trauma informed treatment as outlined in the Ohio Legal Rights Service's, *A Closer Look: Trauma Informed Treatment in Behavioral Health Settings*, January, 2007.

9) Facilitate trauma informed training for all inpatient staff that provides acute care psychiatric services to children and adolescents.

10) Provide financial support for trauma-specific trainings, for example, trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR). These efforts should include the availability of ongoing consultation and training.

11) Support the use of inpatient acute care psychiatric service providers for children and adolescents of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT).

F. Greater Collaboration needed with the Physical Health System

The mental health system does not operate in a vacuum: The system is dependent upon the physical health system both in the pre-admission stage, during hospitalization, and in discharge planning. Especially critical are the activities where the mental health system and physical health system directly interface.

Considerations

1) Create models or incentives for the development of shared mental health emergency services with physical health care providers.

2) Consider psychiatric expertise at targeted emergency departments to minimize admissions through emergency departments.

3) Encourage the continued development of integrated mental health and physical health care in Ohio, including the development of standards and training for said integration within each community mental health center.

4) Establish the requirement for a special audit of any county that exceeds a threshold of five percent of PASSR referrals for convalescent stay in a nursing facility of county residents discharged from psychiatric hospitals.

5) Establish the requirement for a special audit of any county that exceeds a threshold of ten percent of PASSR referrals being denied from any nursing home in the county.

G. Recruitment, Training and Retention of Key Mental Health Personnel

The demand for competent mental health services requires that patients or clients have access to a sufficient number of qualified and culturally competent treatment providers. The human resource is the most dynamic arsenal in the mental health services field. Unfortunately, the human resource in many of the professions, especially psychiatry, is nearing a crisis situation in the not too distant future. The 'graying' or aging out of professionals in several of the fields, in particular psychiatry, means that there will be

insufficient number of trained mental health professionals to meet the ever increasing demand for services.

The lack of cultural diversity in nearly all the mental health professions is an ongoing problem where only small improvements have taken place in a couple of the professions, namely social work and psychosocial rehabilitation.

The on going development of future mental health professionals is a continuing priority and efforts need to be consistently made in developing and maintaining relationships with Ohio colleges and universities. Unfortunately, in the field of psychiatry, there appears to be a reduction in the number of new psychiatrists. As the large numbers of elderly psychiatrists retire the gap will be profound.

Considerations

- 1) Given the 'graying' of many disciplines in the mental health field, there is a need to open up additional ways for persons with mental illness to receive timely and competent services. There is a need to revise the present reimbursement rules to allow for Independently Licensed Social Workers, Licensed Psychologists, and Clinical Nurse Practitioners to be able to serve this population without the requirement of an agency affiliation or supervision by a psychiatrist.
- 2) In order to stimulate career interest in the behavioral health fields, work with the state funded colleges and universities to develop state of the art curriculum. The behavioral health fields would include: psychiatry, psychiatric nursing, clinical social work, clinical psychology, clinical counseling, psychosocial rehabilitation and psychiatric case management.
- 3) Consider cultural competency standards as an on going requirement for the persons in the mental health field.
- 4) Encourage the recruitment, training, and retention of persons from minority cultures in the mental health fields. The development of greater cultural diversity needs immediate attention with benchmarks set to measure progress.
- 5) Review the payment process and prior hospital authorization process among managed care entities and Medicaid/Medicare.
- 6) Develop performance based merit pay for community provider staff based on client treatment outcomes.

Appendix A

HISTORY OF INPATIENT MENTAL HEALTH TREATMENT IN OHIO

Appendix A

History of Inpatient Treatment in Ohio

Preface

It is fitting that a look back, if you will, is included in the Updated Report on the status of the crisis in the acute care treatment of persons with mental illness in the year 2010. As the reader will discover, many of the issues that we grapple with today are not all that different from those that confronted our predecessors in the mental health field. As well, many of our hopes and values that we hold so dear, i.e. recovery model, are not really all that novel of concepts. Two hundred years ago, some early pioneers in the mental health spoke of recovery as a sanguine expectation. In many ways, we have come a long way in the understanding and care of persons with mental illness. Certainly our understanding of the etiology and effective treatments has advanced over the years. What is perhaps most revealing is that over the past two and a half centuries of mental health care, each generation sought to employ the then state of the art treatments based on what they valued, what they understood about mental illness, the resources at their disposal, and the social, economic, and political environments in which they lived. Today, we too strive to employ current state of the art treatments based on what we value, what we understand about mental illness at the present time, the resources we have at our disposal, and the influence of the social, economic and political arenas in which we live. Our forerunners did the best they could at the time; hopefully, we too always strive to do the best we can.

This history of inpatient care in Ohio is based in large part on the following references: *Milestones: A brief history of Ohio's public mental health system*, compiled by Samuel Hibbs, former Public Relations Director for ODMH; the excellent book written by Gerald N. Grob, Ph.D. entitled, *The Mad Among Us: A History of the Care of America's Mentally Ill*. Dr. Grob's book is well researched and provides an excellent source of information about the evolution of mental health care in the United States; *The Pane of Glass* by John B. Martin. Mr. Martin used the then Columbus State Hospital, now Twin Valley Behavioral Healthcare, as the prototype state mental hospital for his poignant examination of the treatment of persons with mental illness in the mid 1950s; Dr. Henry Hurd, et. al. provided a nice overview of the founding of each of the state hospitals in Ohio in their book, *The Institutional Care of the Insane in the United States and Canada*; and, *Hilltop: A Hospital and a Sanctuary for Healing, its Past and its Future* by Drs. Marion E. Sherman and George W. Paulson. Dr. Sherman and Dr. Paulson provide a thorough and fact-filled history of the state hospital in Columbus located on the west side, and we thank them for their narration of the state hospital on "The Hilltop." The term 'hilltop' has come to designate the name of the neighborhood that surrounds the hospital as well as the hospital itself. An individual who desires a more serious exploration into the history of mental health treatment is encouraged to study these references as a sound foundation.

Inpatient Treatment of the Mentally Ill in Ohio before the Civil War

During the colonial times and the early decades of the fledgling United States of America, the treatment of persons, who were referred back then as “distracted,” was localized and primarily the responsibility of the afflicted person’s family.⁴²⁹ The distracted person was viewed as an individual and family concern, and not a social problem. The early colonialist, being New World immigrants, brought with them their Old World European beliefs and customs. Suffering from mental illness, or being distracted was viewed in the context of a moral weakness or from a religious context, under the influence of evil forces. The distracted person’s family was expected to provide for the basic necessities of life and care for their loved one the best they could. Rather than viewed as a medical concern needing treatment, the greater community looked upon the mentally ill person as someone who needed to be cared for from an economic perspective as he or she was unable to provide for themselves.

In the sparsely developed territory north and west of the Ohio River, there were few settlements dotting what was to become the state of Ohio. The economy was overwhelming agricultural and the vast majority of the early immigrant settlers lived widely apart from one another. As a result, during the initial settlement of the Ohio territory by the European immigrants, the pioneers did not have a well defined sense of belonging to a community nor of a community responsibility. As the territory became more settled, pockets of pioneers began to live in closer proximity for safety and security reasons, especially from the indigenous Native Americans who resisted their intrusion. Gradually, villages began to develop, and along with this development was an increasing awareness of community.

A person afflicted with mental illness would only come to the attention of the local authorities in the slowly growing settlements, if the family was unable to adequately care for them and the distracted person’s behavior caused a public concern. Absent a well defined understanding of mental illness, the early public interventions were to place the distracted people in public almshouses or poor houses. This community policy was based on the old English Poor Laws that dated back to the late 1500’s. The Poor Laws set forth the premise that the general society had a responsibility to care for those persons who were unable to care for themselves due to being impoverished or other adverse situations. The American colonies, being initially subjects of the British Crown, adopted many of the English laws that they were most familiar with.

The fundamental values of community responsibility were also a common thread between the colonialist and their previous homeland. The treatment of the mentally ill in the American colonies involved at times putting them in stocks, selling them as slaves or in the case at Salem, Massachusetts, burning them for allegedly being witches.⁴³⁰ The first hospital in the American colonies to admit mentally ill patients was the

⁴²⁹ Gerald Grob, Ph.D. *The Mad Among Us: A History of the Care of America’s Mentally Ill*, New York: The Free Press, 1994, p. 5.

⁴³⁰ John B. Martin, *The Pane of Glass*, New York: Harper & Brothers, 1956, p. 45.

Pennsylvania Hospital in Philadelphia. The hospital opened in 1752. The mentally ill persons were frequently kept in chains fastened to the walls of the institution. The attempts to treat them involved shaving and blistering their scalps and bleeding or purging them.⁴³¹ The underlying premise for these treatments was based on the *Galenic humoral* tradition. The *humoral* tradition purported at the time that diseases were due to an excess production of one of the following bodily fluids: blood, yellow bile, black bile and phlegm. To eliminate the disease required that one or more of the bodily fluids be removed.⁴³²

In the late decades of the eighteenth century, the dispersed settlements grew into villages. Some villages evolved into towns or cities. Gradually the communal framework of the American society began to evolve as well. With an increase in populations throughout the United States and especially in the area of the newly formed state of Ohio, more people were coming into relative close proximity with one another. Transportation advances (including the use of the rivers, canals, railroad and a national road), all contributed to a greater mobility of people. The early decades of the nineteenth century saw a marked increase in immigration from various parts of the globe, and especially the European continent.

With these societal developments, a growing awareness of social issues arose. Diseases became more widespread due to the closer proximity of people. Aberrant behavior became more readily recognized. How to deal with the aberrant behavior was a continuing conundrum. Slowly, there was an increased understanding of mental health issues and the need to develop effective treatment options.

The understanding of mental health treatment moved forward principally based on the concomitant groundbreaking work of two men on opposites sides of the Atlantic: Philippe Pinel in France and William Tuke in America. Philippe Pinel challenged the pessimistic medical and psychiatric assumptions prevalent at the time, and in line with the Age of Enlightenment in European thinking, he challenged the previous notions on how best to treat persons who were 'distracted'. He reasoned that the common practice of bleeding and corporal punishment were not only cruel but ineffective. He expressed in his landmark work, *A Treatise on Insanity*, "To detain maniacs in constant seclusion...to load them with chains; to leave them defenceless [sic], to the brutality of underlings...is a system of superintendence more distinguished for its convenience than for its humanity or its success."⁴³³ He postulated rather, the focus of treatment should be on instilling hope with the "possibility and probability of recovery."⁴³⁴ Pinel argued that a well-run asylum held out the better promise for recovery, and that the asylum should be so organized to respond to the "varied needs of the insane and proclaim from afar the respect due to distress and misfortune."⁴³⁵ Pinel is credited with literally striking the chains off those persons who were felt to be afflicted with insanity.

⁴³¹ *Ibid.*

⁴³² Grob, p. 7.

⁴³³ Philippe Pinel, *A Treatise on Insanity* (English Translation), Sheffield, England: W. Todd, 1806, p. 184.

⁴³⁴ Grob, p. 27.

⁴³⁵ *Ibid.*, p. 27-28.

Across the Atlantic Ocean, William Tuke, a member of the Religious Society of Friends commonly known as Quakers, founded the first American hospital for the mentally ill known as the York Retreat.⁴³⁶ The York Retreat was “a humanitarian hospital where kindness replaced restraint and abuse.”⁴³⁷ In 1846, Dr. Thomas S. Kirkbride, who would later be credited with the architectural design for many of the mental hospitals throughout the country including in Ohio, wrote glowingly of the work of Pinel and Tuke, citing, “ by a singular coincidence, without knowledge of each other’s movement, were at the same time, in different kingdoms, engaged in the same noble work of discarding time honoured prejudices and abuses, and from actual practice, giving to the world a code of principles for the moral treatment of Insanity, which even now can hardly be improved.”⁴³⁸

The first hospital exclusively for the treatment of persons with mental illness was built at Williamsburg in the Virginia colony. The hospital, named the Virginia Eastern Asylum, was built by an enactment of the legislature and opened in 1773, three years before the Declaration of Independence.⁴³⁹ The action of the Virginia colony was profound as it set forth the basic premise that the state government should take the lead in the care of persons with mental illness.

At the conclusion of the Revolutionary War, the newly independent American colonies began to develop a federalist form of government that involved a collection of sovereign states, *the United States*. Still stinging from authoritative rule under the British crown, the founding fathers had little interest in centralizing a federal governmental authority in their new country. The state government was regarded as the preeminent authority. In the early to mid-nineteenth century the role of state governments continued to ascend and it was to the state that the citizens naturally looked to address societal issues. The nation of the United States of America was considered to be a mere collection of sovereign states. Before the Civil War, the federal government had a very limited relationship with the common citizen. Rather, the citizen looked to the state government. This way of thinking may seem a little odd to the reader in the early twenty-first century, as we now generally look to the federal government for assistance and support of many facets of our lives. That clearly was not the case in the mid-nineteenth century.

Consistent with mid-nineteenth century political philosophy, the state governments divined the need to develop centralized institutions of care to address many societal issues and care for those who could not care for themselves. During this time institutions were built to care for persons who were deaf, blind, mental retarded, and mentally ill. In fact, whereas in 1820 no state had an institution for the mentally ill, by the beginning of the Civil War in 1861, all states had built at least one institution.⁴⁴⁰

⁴³⁶ *Ibid.*, p. 28.

⁴³⁷ Martin, 45.

⁴³⁸ Grob, p. 29.

⁴³⁹ Martin, p. 45.

⁴⁴⁰ Gerald N. Grob, Ph.D., *The Chronically Mentally Ill in America: the Historical Context; Mental Health Services in the United States and England, Struggling for Change* by the Robert Wood Johnson Foundation, Princeton, N.J., 1990.

Ohio experienced remarkable population growth since achieving statehood in 1803. The 1800 census listed a population of 45,365 residents in the part of the Northwest Territories that was to become the state of Ohio. In just twenty years, the state population had grown twelve fold to 581,484. The remarkable growth in population continued throughout the first half of the nineteenth century. By 1850, the population had increased 1,980,329. Indeed, by 1860, Ohio was the third most populated state in the Union, despite being only fifty-seven years old as a state.⁴⁴¹ Along with the growth in the general population was the increase in the number of persons who were considered mentally ill. The 1860 census would enumerate 2,275 Ohioans as being mentally ill or 'insane', the new colloquial term that was now in vogue in place of 'distracted'.⁴⁴² The rapid growth in the number of persons who needing cared for because of mental illness required the state leaders to investigate innovative ways to care for them.

Fortunately for Ohioans, during the state's rapid growth during the nineteenth century, it was guided by state leaders who understood the need to develop programs and institutions to care for the societal needs of its citizens. For example, in the 1860 census, Ohio ranked number one among the states in the number of public schools and public school teachers. Ohio ranked second only to more populated state of New York in the number of pupils enrolled in school.⁴⁴³ Ohio also ranked first in the number of colleges, professors, and college students enrolled in their higher learning institutions.⁴⁴⁴ To pay for these educational programs, Ohio ranked third in annual taxes collected for schools. But with respect to overall taxes paid to the state, Ohio ranked first.⁴⁴⁵ A portion of the state taxes collected were used to care for the growing number of Ohioans who were poor or were persons with a mental illness.

In Ohio, the first law enacted for the care of the mentally ill was passed in 1815. The state was only twelve years old at the time. Six years later, the first institution for the mentally ill was constructed in Cincinnati. Funds were appropriated in 1821, and the facility opened in 1824. The state provided financial assistance through the form of a tax rebate to provide support for the Hamilton County asylum located in then the largest city in Ohio, Cincinnati.⁴⁴⁶ Dr. Daniel Drake is credited with spearheading the development. The first institution built west of the Allegheny Mountains was initially named the Commercial Hospital and Lunatic Asylum for the State of Ohio at Cincinnati.⁴⁴⁷ The purpose of the asylum was "for the safekeeping, comfort and medical treatment of such idiots, lunatics and insane persons of the state as might be brought to it for these

⁴⁴¹ J. Disturnell, *Census of the United States and British America*, New York: American News Company, 1867, p. 4.

⁴⁴² U.S. Secretary of the Interior, *Statistics of The United States in 1860*; compiled from the Original Returns and being the Final Exhibit of The Eighth Census, Washington, D.C.: Government Printing Office, 1866, p. 639.

⁴⁴³ *Ibid.*, p. 506.

⁴⁴⁴ *Ibid.*

⁴⁴⁵ *Ibid.*, p. 511.

⁴⁴⁶ Martin, p. 46.

⁴⁴⁷ Henry M. Hurd et al., *The Institutional Care of the Insane in the United States and Canada*, Baltimore, Maryland: The Johns Hopkins Press, 1916, p. 296.

purposes.”⁴⁴⁸ Unfortunately, the initial attempt by the state to care for persons with mental illness required the patients to “not only be confined in cells, but must be separated by thick walls to prevent communication with each other.”⁴⁴⁹ These conditions, though deplorable by modern day standards, were far superior to that which thousands of persons with mentally illness faced who desperately needed to be hospitalized, but were turned away for want of bed space. For them their plight was to be held in county jails, or in outhouses or dog pens. They were exposed to the harsh weather conditions as well as the taunts by reprobate schoolboys. They were fed sparse meals and their “dens” were cleaned out of human waste intermittently.⁴⁵⁰

The state had to do better. On March 5, 1835, the General Assembly of the State of Ohio enacted legislation to establish The Lunatic Asylum of Ohio. The site chosen for this first state hospital was on East Broad Street in the fledgling new state capital town, Columbus. The building of the first state hospital at Columbus had less to do with its being the state capital and more based on the central location in the state. At the time, many state governments chose to construct their social institutions near the geographic center of their respective state, regardless of where the main population centers were in the state. The rationale was that this way all residents of the state would have equal geographic access to the facility.⁴⁵¹ With the new state mental health facility in Columbus, the hospitalized patients at the Cincinnati asylum were required by law to be moved to the new facility. The Cincinnati facility would be converted to a general purpose hospital for the time being.⁴⁵²

The new hospital was located approximately one mile east of the present Statehouse. The hospital was built on sixty-four acre tract of land on the north side of Broad Street across from where Parsons Avenue terminated at Broad Street.⁴⁵³ The hospital was built with primarily convict labor at the bargain price of \$150,000.⁴⁵⁴ The facility opened on November 30, 1838.⁴⁵⁵ The hospital was named the Central Ohio Lunatic Asylum.⁴⁵⁶ Ohio, though still a young state barely thirty-five years since statehood, could take pride in being one of only three states who had the foresight to publicly fund and construct a hospital for the treatment of the mentally ill before 1840. (The other two states were Massachusetts and Vermont.)⁴⁵⁷ The first Ohio state hospital superintendent was Dr. William M. Awl. The hospital was designed to care for no more than one hundred forty patients at the time. The hospital quickly filled its beds, and an expansion was quickly called for.⁴⁵⁸

⁴⁴⁸ *Ibid.*

⁴⁴⁹ *Ibid.*, p. 297.

⁴⁵⁰ Martin, p. 53.

⁴⁵¹ Grob, *The Mad about Us*, p. 50-51.

⁴⁵² Hurd, p. 298.

⁴⁵³ Marion E. Sherman and George W. Paulson, *Hilltop: A Hospital and a Sanctuary for Healing, its Past and its Future*, Fremont, Ohio: Leshner Printers, 2008, p. 41.

⁴⁵⁴ Martin, p. 46.

⁴⁵⁵ Henry M. Hurd *et al.*, editors. *Institutional Care of the Insane in the United States and Canada, Vol. III.* Baltimore, Md.: Johns Hopkins Press, 1916.

⁴⁵⁶ Martin, p. 46.

⁴⁵⁷ Grob, p. 45.

⁴⁵⁸ Martin, p. 46-47.

Dr. Awl described the patients and their situation at the hospital as coming from across the state and displaying a wide variety of mental illness “from the driveling IDIOT up to the raging MADMAN...” Dr. Awl observed the ill effects on their condition from the long standing nature of their illness and the abuse and mistreatment accorded them while confined in the county jails, “private dungeons” and the infamous poor houses. Dr. Awl noted that at the asylum the patients were washed, provided decent food and clothing and made to feel comfortable. He exhorted that “under the smiles of a beneficent Providence...[the hospital] must succeed and command attention and respect, both at home and abroad, to the glory and praise of this high minded, great and benevolent state.”⁴⁵⁹

The primary focus of the staff was on the compassionate care of the patients to assure their basic needs were met. Beyond that, attempts were made to treat their symptoms based on the limited mental health and medical understanding at the time. A patient at the new hospital commented on his and his fellow patients’ situation at the new hospital. The patient observed the improved treatment offered to them. He noted that should a patient act out, “he is either confined in his own room, or perhaps conducted to the shower box, where water is admitted upon him from a cistern above, in such copious streams as may cool his blood down to a degree of temperature sufficient for enabling him to reflect on the impropriety of his conduct, and to train him for again becoming a harmless member of society.” Overall, the patient’s assessment was that the “place seems a paradise in which one might live with pleasure and leave with regret,”⁴⁶⁰ Certainly a far cry from the previous conditions.

The General Assembly of Ohio well understood its responsibility to care for persons with mental illness. In 1851, the legislature adopted an amendment to the Ohio State Constitution that legally required that “Institutions for the benefit of the insane, blind, and deaf and dumb, shall always be fostered and supported by the state; and be subject to such regulations as may be prescribed by the General Assembly.”⁴⁶¹ The following year, the General Assembly enacted legislation to build two more asylums: the Southern Ohio Lunatic Asylum at Dayton and the Northern Ohio Lunatic Asylum near Cleveland.⁴⁶²

The Northern Ohio Lunatic Asylum opened on March 5, 1855 near the Cuyahoga River valley “in a veritable wilderness” southeast of Cleveland. The facility was designed for one hundred beds. Dr. Leander Firestone served as the first superintendent. Demand for admissions quickly filled all the beds, and in the facility was enlarged to attempt to keep up with the incessant demand.⁴⁶³

The Southern Ohio Lunatic Asylum at Dayton opened on September 1, 1855.

⁴⁵⁹ *Ibid.*, p. 47.

⁴⁶⁰ *Ibid.*, p. 47-48.

⁴⁶¹ *Ohio Constitution*, 1851, Article 7, Section 7.01.

⁴⁶² Hurd, p. 298.

⁴⁶³ *Ibid.*, p. 315.

The facility was built on fifty acres of land to the southeast of the town. The property was situated on top of a hill that provided a grand view of the Miami River valley. Dr. Joshua Clements served as the first superintendent. The initial capacity was set at eighty patients, well under the two hundred census standard established as critical for the moral or caring treatment established by the national association of superintendents. The demand quickly exceeded the bed space. In response, the hospital was enlarged to twenty wards. The facility also included an amusement hall, a chapel and administrative space.⁴⁶⁴

The impetus for this further development was in major part due to the tireless efforts of Dorothea L. Dix. Ms. Dix had spent the past decade championing the cause for improved care of the mentally ill throughout the eastern United States. She cajoled the state legislatures to fund and construct more mental hospitals in their jurisdictions. Bolstered with her successes with state legislatures, Ms. Dix attempted to “persuade [the U.S.] Congress to enact legislation that would authorize the distribution of five million acres of federal lands to the states, the proceeds of which would be used to care for the indigent insane.”⁴⁶⁵ Initially, it appeared her efforts were successful as Congress passed the bill in 1854 that provided ten million acres for this purpose.

However, President Franklin Pierce vetoed the bill, citing as the reason for his action that, “the foundations of charity will be dried up at home, and the several States, instead of bestowing their own means for the social wants of their own people, may themselves, through the strong temptation, which appeals to States as to individuals, become humble supplicants for the bounty of the Federal Government, reversing their true relation to this Union.”⁴⁶⁶ The President’s veto, which Congress failed to override, effectively ended any major involvement of the Federal Government in mental health policy for nearly one hundred years.⁴⁶⁷

With the federal government on the sidelines regarding mental health policy and by extension, funding, the issue of how to pay for the growing number of state institutions became a delicate political matter. Initially, private citizens with means were expected to pay for their care. However, this provision aroused the blatant distinction between those who could pay for their own care and those who could not. Dr. Awl and others of the Ohio Lunatic Asylum cautioned in 1851 that “the distinction was invidious; its bad consequences were manifold, and far outweighed all pecuniary advantages...often did our halls resound with the exclamation, ‘You are only a pauper, I pay for my board.’”⁴⁶⁸ In consequence, the directors of the Ohio Lunatic Asylum abolished all charges for care for everyone. Throughout many of the states, including Ohio, the state and local governments were to work together to fund the state run facilities. The local county or township government would be charged a fee to cover a portion of the care of the citizens from their community. This arrangement was dependent upon the cooperation

⁴⁶⁴ *Ibid.*, p. 312.

⁴⁶⁵ Grob, p. 97.

⁴⁶⁶ *Ibid.*

⁴⁶⁷ *Ibid.*

⁴⁶⁸ *Ibid.*, p. 86.

of all to assure sufficient revenue was generated. However, as Dr. Grob observed, “the very creation of an institutional-based public policy within a political system that divided authority tended to encourage efforts to shift costs to different levels of government irrespective of the needs of mentally disordered persons.”⁴⁶⁹

With the incessant growth of the population in the Buckeye state, the need for additional hospital beds for the mentally ill became increasingly more apparent. Aspiring to maintain the hospital census at less than two hundred patients at each facility, the General Assembly foresaw the need for another hospital in Cincinnati; this new facility would be named the Longview Asylum. A new county run asylum has been built there in 1854. In 1857 the General Assembly divined a novel financing plan wherein the state would turn over taxes raised from Hamilton County residents that were intended for the care of the mentally ill statewide, back to Hamilton County to run their county asylum.⁴⁷⁰ At the time it was noted that the “Longview Asylum is an anomaly in the system of the state governing the care of the insane. It is regulated by a special act in the Legislature, limited in its operation to this [Hamilton] county.”⁴⁷¹ Longview Asylum opened in 1860 with O.M. Langdon serving as its first superintendent. The unique funding strategy for the Longview Asylum was the first example of the state redistributing revenue back to a local authority. One hundred and thirty-one years later, the landmark Mental Health Act of 1988 would follow this precedent, at least in principle.

By the start of the American Civil War in April, 1861, Ohio had three state operated mental hospitals and the county operated, but state financed, hospital in Hamilton County. The mental hospital was the foundation for mental health policy not only in Ohio, but in the rest of the United States.⁴⁷² Within these facilities, the primary goal was the compassionate care of the patients with a secondary objective being to provide them with moral treatment. In order to accomplish these goals effectively, a major effort was to maintain the resident populations at manageable and therapeutic levels, that is, less than two hundred and fifty patients. The Association of Medical Superintendents of American Institutions for the Insane (the predecessor organization of the American Psychiatric Association) revised the therapeutic threshold of the number of residents.⁴⁷³ The small size of the facilities would allow the superintendent to make daily rounds and greet each patient by his or her name. Dr. Awl, superintendent of the Columbus facility, noted that his intent each day was to “appeal to his patients’ emotions and to influence them with kindness and understanding to return to sanity.”⁴⁷⁴ Dr. Awl was representative of the other superintendents who “denounced the restraint of violent patients. He believed mental patients were not very different from ‘normal’ people...He tried to improve the quality of his attendants...and required them to treat the patients as human beings. His hospital, and others, was suffused with an atmosphere of hopefulness.”⁴⁷⁵

⁴⁶⁹ *Ibid.*, p. 97.

⁴⁷⁰ Hurd, p. 298-299.

⁴⁷¹ *Ibid.*, p. 339.

⁴⁷² Grob, p. 53.

⁴⁷³ *Ibid.*, p. 72.

⁴⁷⁴ Martin, p. 50.

⁴⁷⁵ *Ibid.*, p. 50-51.

The manageable size of the hospitals combined with the new focus on moral treatment in a supportive and caring environment allowed the superintendents to proudly assert high percentages of recovery or cure rates. Dr. Awl claimed that during the first four years of the Ohio Lunatic Asylum, he and his staff achieved an eighty percent recovery rate among persons who were recently admitted and ill for less than a year.⁴⁷⁶ The longer the period of time for the mental illness to be established, the lower the recovery rate. For example, for those ill between two and five years, the recovery rate declined to thirty-five percent. For those persons who were ill from five to ten years, the recovery rate dropped to nine percent.⁴⁷⁷ Because of the high recovery rates reported by Dr. Awl, he earned the sobriquet, “Dr. Cure-Awl.”⁴⁷⁸

Inpatient Treatment of the Mentally Ill in Ohio from the Civil War to post-World War II

While the nation was split and preoccupied with the devastating Civil War, progress still continued in the area of mental health care. Dr. Thomas S. Kirkbride, who was a founder of the American Psychiatric Association, conceptualized the ideal criteria for the placement and design of new mental hospitals. The superintendents’ association adopted his plan. The design was referred to variously as the Kirkbride, the congregate or the block plan. According to Dr. Kirkbride’s plan, the ideal hospital location had these characteristics: built outside an urban area, but with easy transportation access; good drainage site with an abundant fresh water supply and proximity to fertile land; aesthetically appealing landscaping,⁴⁷⁹ and ample land for growth as needed.

Once the appropriate site was chosen, the building design was paramount as the layout of the building would not only provide the patients with sound shelter and the basic necessities of life, but also assist “in the creation of a therapeutic environment and enhanced [the] appropriate classifications of patients.”⁴⁸⁰ The building design was formally called the linear plan and the plan involved:

- A center building that would house the superintendent and his family (at that time, all superintendents were men) as well as the administrative offices and living quarters for the staff; The center building could also house the medical clinic, food service, auditorium/recreation hall and chapel.
- Spreading out laterally on both sides were the patient wings. Each wing was to be nearly 150 feet in length. The wings were segregated by gender. Each wing then was comprised of wards that were defined as either lower or higher. The intent was to separate out the patients according to their mental condition and prognosis among the wards. In some cases, the more acutely ill or disturbed

⁴⁷⁶ Grob, p. 99.

⁴⁷⁷ Ibid.

⁴⁷⁸ Martin, p. 51.

⁴⁷⁹ Grob, p. 71-72.

⁴⁸⁰ Ibid., p. 72.

were housed in the higher wards or the wards furthest away from the center building. In some hospitals, as the patient improved, he or she would be moved closer to the center building and then released.⁴⁸¹ In other hospitals, the reverse direction was followed. This classification of patient condition and their placement on a specific ward, accordingly, led to the colloquial phraseology of 'back ward' to define those persons whose condition was too refractory to anticipate discharge anytime soon.⁴⁸²

- Adjoining additional wings, if growth in the population was anticipated. Especially significant was the requirement of the linear plan that called for the additional wings to be built at right angles or "lapping on at the end and extending in a parallel line."⁴⁸³ This design allowed for the cross ventilation of air from all four directions on each ward.
- The interiors of the hospital were to be attractive, but always with safety and security foremost. Thus, while exquisitely carved woodwork and stained glass dressed up the common areas of the central building; steel bars were placed on the windows in the patient's rooms and the common areas of the wards.

The Athens Lunatic Asylum was the first mental hospital in Ohio to be built following the Civil War. The Athens facility was also the first to be built with the Kirkbride linear design. The hospital was built in southeastern Ohio just across the Hocking River from the town of Athens. Adhering to the plans for the ideal hospital, the facility was built on a moderately sized hill just up the bank from the river. The site was considered to be "the most picturesque and beautiful of any state institution in Ohio."⁴⁸⁴ After six years of construction, the facility admitted its first patients on January 9, 1874. Before the first patient was admitted, the name of the building had changed to the Athens Asylum for the Insane.⁴⁸⁵ The first superintendent was Dr. Richard Gundry. The initial occupancy rate was designed at forty patients. In short time, as with the other hospitals, the state would find it necessary to expand the size of the facility to accommodate the increasing need.

Tragedy struck the night of November 18, 1868. A fire broke out at the Ohio Lunatic Asylum in Columbus that nearly destroyed the entire facility. Six patients died in the inferno. The remaining patients were transferred to the other state institutions at the time as well as to the school for the deaf and to the county homes.⁴⁸⁶ Initially, in 1869, the Ohio General Assembly allocated funds to rebuild the hospital on the same location. Work had begun when in 1870 the General Assembly decided to scrap the reconstruction effort and instead sell the land and acquire another location. The two reasons for the change in plans were: 1) Columbus was growing greatly after the Civil War, especially toward the east side of town. The land on which the asylum sat was increasingly more valuable for other residential or commercial development; 2) In

⁴⁸¹ Ibid.

⁴⁸² Martin, p. 10.

⁴⁸³ Grob.

⁴⁸⁴ Hurd, p. 321.

⁴⁸⁵ Ibid., p. 320.

⁴⁸⁶ Martin, p. 53.

adherence to the Kirkbride plan, the present location did not meet the now accepted requirements.

The General Assembly looked westward and decided on the William S. Sullivant farm located atop a hill on the national road on what became West Broad Street. The location was removed from Columbus where development on the west side (Franklinton) was slowed due to the constant concern over the flooding of the Scioto River. The new location still had easy transportation access being located on the national road. The national road had been improved due to the construction of the federal Camp Chase training and prison facility during the Civil War just a mile west of the Sullivant farm. The cornerstone for the new Columbus Asylum was laid in place on July 4, 1870. Governor Rutherford B. Hayes presided over the ceremony; seven years later he would be the elected the nineteenth President of the United States.

The new Columbus Asylum facility was prodigious by the standards of the day and required seven years to finally complete construction. When finally finished, the building received high praise being acclaimed “the most complete in all the land...one of the best in the world.”⁴⁸⁷ At the time, “it was said to be the largest institution of its kind on earth.”⁴⁸⁸ Legend had it that the building maintained its title as the largest institution on earth until the Pentagon was constructed in Washington, D.C. in 1943.

Impressive it was indeed. Built according to the Kirkbride model, branching off from the center building were the two wings for the patients; the male wards to the south, and the female wards to the north. Ever mindful of the reason the new institution was built, special attention was made to assure it was nearly fireproof. The stairways were structured of steel. The floor was “laid on arches of brick and corrugated iron supported by iron girders; the roof was iron and slate; the partition walls were brick.”⁴⁸⁹ The thick walls were made of brick with dirt encased in between. Only the door and window frames, the ornate woodwork and the balusters for the stairwells in the center building and the floors were constructed of wood. The only problem with the new facility was its infidelity to the national standard of holding no more than two hundred and fifty patients. Within three months of its opening, it was already at the capacity of eight hundred and fifteen patients.⁴⁹⁰

Ohio’s population continued to grow. The influx of immigrants both before and after the Civil War had accelerated the naturally rapid growth. The present collection of state hospitals were all in the process of additional construction to try to keep up with the demand; without success as it was reported that there were “not less than 1,000 insane persons in the jails and [county] infirmaries of the state” in 1883.⁴⁹¹ Another facility was needed. Unfortunately, the state coffers were sparse and the average cost of building a

⁴⁸⁷ *Ibid.*, p. 54.

⁴⁸⁸ *Ibid.*

⁴⁸⁹ *Ibid.*

⁴⁹⁰ *Ibid.*

⁴⁹¹ Hurd, p. 324.

mental hospital came out to \$1,500 per capita.⁴⁹² The state looked to a less expensive building design. Abandoning the Kirkbride model, the General Assembly settled on a cottage model of detached buildings with a congregate dining area as conceived by General Brinkerhoff of the State Board of Charities. The General asserted that the cottage model could be built for nearly one third the price per capita as the larger institutions recently constructed. Looking around for an appropriate site to build the cottage model, the General Assembly was persuaded by the donation of one hundred and sixty acres of land by the Lucas County officials in Toledo.⁴⁹³

The innovative cottage model design had plenty of detractors who ridiculed the concept referring to it as the “Cattle Ranch Plan.”⁴⁹⁴ What was more, there was only one other design of its kind in the country being built in Illinois. It was dubbed by its proponents as “the pioneering undertaking of its kind in the world.”⁴⁹⁵ Regardless of the hyperbole on both sides, the plans continued for construction of the cottages that could house up to one thousand patients. There were more construction delays due to political changes at the state level and the discovery of quicksand on the property; but finally after two years the cottages were ready to receive the first patients in 1885. The first superintendent was Dr. H.A. Tobey.⁴⁹⁶

On September 6, 1898 the latest new mental hospital received its first patients. The Eastern Ohio Asylum for the Insane opened at Massillon. Dr. A.B. Richardson would serve briefly as its first superintendent. Dr. Richardson was selected to be the superintendent for the Government Hospital in Washington, D.C., that would later be called St. Elizabeth’s. Succeeding Dr. Richardson at Eastern Ohio Asylum was Dr. Henry C. Eyman.⁴⁹⁷ The Massillon facility was built by the cottage design that had proved financially and programmatically successful at Toledo. As with the other mental hospitals, a great deal of attention was focused on agricultural pursuits. “The hospital owns and leases about 1100 acres of choice farm and garden land. Practically all the vegetables required in the dietary are furnished by the farm, and the work of cultivating and gathering the crops is done by patients, under the direct supervision of a medical officer,”⁴⁹⁸ Superintendent Eyman noted. Superintendent Eyman further offered with pride that, “chemical and mechanical restraints are practically obsolete terms. Air, exercise, and hydrotherapy have been substituted. Diversion and occupation are relied upon largely for the betterment of the patients.”⁴⁹⁹ At the conclusion of the nineteenth century, the State of Ohio was operating six mental health institutions spread across and situated in all four corners of the state. Across the United States, the building and operating of mental hospitals represented the largest social benefit investiture by the sovereign states during the nineteenth century.⁵⁰⁰

⁴⁹² *Ibid.*, p. 325.

⁴⁹³ *Ibid.*, p. 326.

⁴⁹⁴ *Ibid.*

⁴⁹⁵ *Ibid.*

⁴⁹⁶ *Ibid.*, p. 329.

⁴⁹⁷ *Ibid.*, p. 330.

⁴⁹⁸ *Ibid.*, p. 330-331.

⁴⁹⁹ *Ibid.*, p. 331.

⁵⁰⁰ Grob, p. 132.

Toward the end of the nineteenth century, the classification of major mental disorders was revised by the work of Dr. Emil Kraepelin. Dr. Kraepelin classified major mental illnesses into two broad categories: dementia praecox or manic-depressive psychoses. Dementia Praecox included the chronic mental disorders that included symptoms of catatonia and hebephrenia. The prognosis was very poor for these conditions that were considered to be irreversible and would lead to dementia. On the other hand, the manic-depressive psychoses were felt to be cyclical in nature and thus held the potential for recovery.⁵⁰¹ Dr. Kraepelin viewed mental illness as a disease that would run an observable course. Dr. Kraepelin also “assumed that mental disease was, like any other disease, due to a defective organ, to heredity, to metabolic changes, or to imbalance of the endocrine gland secretions.”⁵⁰² The significance of his work was to finally fuse psychiatry with the larger medical field.

A decade or so later, Swiss psychiatrist Dr. Paul Eugen Bleuler revised Dr. Kraepelin's concepts and redefined Dementia Praecox as Schizophrenia. In his work, *Dementia Praecox, the Group of Schizophrenias*, Dr. Bleuler postulated that schizophrenia was “a group of psychotic reactions to reality rather than as a single formal disease...as a reaction of life which may be cured because it sometimes cures itself—many schizophrenics recover spontaneously.”⁵⁰³ Dr. Bleuler's work was considered by some to be “most important contribution to psychiatry made by the twentieth century;”⁵⁰⁴ and the century was barely a decade old.

While the thinking of psychiatry was evolving across the globe, in Ohio concern was raised over patients who were too violent to maintain safely in the regular institutions for the mentally ill. In addition, all the hospitals were receiving patients who were charged with criminal offenses, but who could not be sent to prison due to their mental condition. The Ohio General Assembly passed an act in April, 1906 that created the Lima State Hospital for the Criminal Insane.⁵⁰⁵ The new hospital was to be built in the small community of Lima in northwest Ohio approximately halfway between Toledo and Dayton. A commission was appointed to study and recommend the design for this type of a facility. At the time, there were only four other forensic facilities in the United States, two in New York, one in Michigan, and one in Massachusetts. The commission visited these four institutions and derived ideas to incorporate in the design of the Lima facility.

Compared to Ohio's other state mental hospitals, Lima State was spartan. The facility was generally barren of ornamentation, and all the furnishings were designed to be “simple and durable...the whole indicates construction for utility alone.”⁵⁰⁶ The building was designed using the pavilion plan that featured: two stories, a series of buildings

⁵⁰¹ Martin, p. 65.

⁵⁰² *Ibid.*

⁵⁰³ *Ibid.*, p. 66.

⁵⁰⁴ *Ibid.*

⁵⁰⁵ Hurd, p. 333.

⁵⁰⁶ *Ibid.*, p. 334.

connected by one corridor in the shape of a parallelogram. There was a courtyard of nearly three acres located inside the building that surrounded it. The building was constructed on over six hundred acres and it was described as “a large artificial monolith of concrete.”⁵⁰⁷ Clearly the primary focus was on security and safety, and less so on a place of refuge or retreat. The hospital nonetheless had modern treatment facilities including a modern operating room and hydrotherapeutic equipment that consisted of “various kinds of baths, douches, hot cabinets, etc.”⁵⁰⁸ Dr. Charles H. Clark served as the first superintendent at Lima State, which when it opened on April 15, 1915 could house one thousand patients. In less than three months of opening, the facility was at maximum capacity.⁵⁰⁹

During the first quarter of the twentieth century, all of the state run mental hospitals continued to expand, remodel, and attempt to institute the latest innovations in care and treatment that were prevalent at the time. Congregate dining, inaugurated at the Athens facility in 1884, had proven its utility and it was now the norm in all the state run hospitals.⁵¹⁰ Many of the hospitals built under the Kirkbride model, added cottages to the grounds of the hospital. The cottages had proven their economic and therapeutic value. In Northeast Ohio, the population continued to climb rapidly resulting in another facility being built to augment the Cleveland hospital. In 1922, Hawthornden State Hospital opened in rural Summit County. As the need for more beds arose, the facility was changed to a separate hospital in 1941.

Also, in the first quarter of the twentieth century, the hospitals’ administrators observed that the client mix was becoming increasingly more elderly. A significant reason for this demographic change was that the general population was becoming more mobile with many families choosing to move further west for land and opportunity. The aged relatives were frequently left behind to care for themselves. In the era predating the Social Security Act, if the elderly could not continue working to support themselves, they found themselves many times admitted to a state hospital. The county run almshouses had by this time declined in their use owing to their poor reputation. State Care Acts began in Massachusetts and swept across the country. The State Care Acts clearly differentiated the locations and facilities where the mentally ill could be cared for. They were not be cared for by the counties, but rather by the state government. At the same time, senility was gaining acceptance as a form of mental illness. With these changes, the state mental hospitals became the de facto surrogate homes for the elderly.⁵¹¹ With this shift came the savings in local dollars that no longer had the responsibility to care for the mentally ill aged. Conversely, the state coffers were stretched even further by burgeoning increases in the chronic and aged population.

The change in the composition of the patients in the mental hospitals also redefined the role of psychiatry. Heretofore, psychiatry had been correlated with the mental hospitals.

⁵⁰⁷ *Ibid.*, p. 333.

⁵⁰⁸ *Ibid.*, p. 334.

⁵⁰⁹ *Ibid.*, p. 335.

⁵¹⁰ *Ibid.*, p. 359.

⁵¹¹ Grob, p. 120-121.

The leaders of the profession began to reevaluate their role of their profession giving the decidedly chronic population and custodial direction that the state hospitals were taking. The innovative movement was known as dynamic psychiatry. Building on the discoveries of germ theory as well as the work of Sigmund Freud who introduced the theory of the unconscious, psychiatry began moving in two distinct and seemingly opposite directions: 1) toward the development of the psychic theory with psychoanalysis to treat the unconscious realm, and 2) biological factors that could impact on mental disorders.⁵¹² The two directions brought about the development of research institutes and psychopathic hospitals.⁵¹³ A revolution was underway in the field of psychiatry; a revolution that would directly impact on the state hospitals.

A significant development was the discovery of the causative effect of the disease syphilis on the mental condition of the diseased person. The tertiary stage of the disease (known as paresis) involved paralysis, delirium, convulsions that led to dementia and ultimately, death. In 1897, the link between syphilis and paresis was clinically proven. The discovery was critical as an increasing number of initial admissions to the state hospitals were suffering from paresis. By 1930, ten percent of all new admissions were in a paretic state including one-fifth of all male new admissions.⁵¹⁴ The discovery had two significant outcomes:

- 1) The recognition that mental illness could be linked to bodily conditions; i.e. a somatic or organic model of mental disorders;
- 2) The development of targeted biological treatments for the illness.

Induced fever therapy became the accepted treatment for paresis. Fever therapy evolved from the observation that mental symptoms declined in febrile patients suffering from typhoid fever. If a fever could reduce mental symptoms for patients afflicted with one disease, could not the same hold true for paresis? To induce a fever, patients were treated with blood drawn from malaria patients. In short time, "soon every asylum had its 'fever box'."⁵¹⁵ Fever therapy was even attempted in the treatment of persons suffering from schizophrenia.⁵¹⁶

With renewed optimism that biological treatments could be developed to assist the chronic populations in the state hospitals, the next form of treatment to evolve was shock therapy. Several methods were devised to elicit the shock response to the brain. The initial method devised was to administer insulin to the patient and thereby lower the patient's blood sugar level, resulting in a hypoglycemic state which led to convulsions. In this state, the patient lapsed into a coma, and the patient was brought out of the

⁵¹² Ibid., p. 142 and 145; Martin, p. 66.

⁵¹³ Grob, p. 145.

⁵¹⁴ Ibid., 125 and 179.

⁵¹⁵ Martin, p. p. 61.

⁵¹⁶ Grob, p. 180.

⁵¹⁶ Grob, p. 180.

coma by the administration of sucrose.⁵¹⁷ Insulin therapy was considered to be effective for the treatment of schizophrenia.⁵¹⁸

The next method devised was the administration of metrazol, a circulatory and respiratory system stimulant. Large doses of the drug would lead to convulsions and thus the shock therapy.⁵¹⁹ The administration of an electroshock to the patient's brain was the successive adjunct method for shock therapy. Electroshock therapy became in vogue in large part because it was "easy to perform and their use became enormous."⁵²⁰ By 1940, "virtually every mental hospital had introduced one of the new shock therapies."⁵²¹ Some hospitals set up their wards so that on 'ECT day' the ECT staff could move from bed to bed down the ward administering the shock treatment with assembly line-like efficiency.

The development of germ theory and paresis treatment also had an influence on the growth of a new field in psychiatry: mental hygiene. The focus of the mental hygiene movement was on prevention of mental illness in the first place. The basic premise was "that it was possible and easier to prevent mental disorders [than] it was to treat and cure them."⁵²² Although the ultimate goal was social betterment, an extreme form of the movement focused on eugenics in an effort to improve the human gene pool by impacting on reproduction on persons with specific mental disorders.⁵²³

Psychiatry was also branching into defining socially deviant behavior as a form of mental illness; included were alcoholism and hypersexual activity (though the latter diagnosis was interestingly only reserved for females, said behavior being considered culturally normative among males).⁵²⁴

Despite the divergence in the primary focus of psychiatry into non-institutional settings and on acute rather than chronic care, the state mental hospitals continued to receive adequate funding to at least stay on par with the increased demand of admissions. Grob noted, "The resiliency and persistence of hospitals was largely a function of their ability to provide care for large numbers of individuals whose mental illnesses rendered them dependent upon others. The absence of community systems to meet the needs of this disabled population further magnified the importance of the caring and custodial functions of mental hospitals."⁵²⁵ That is, until the Great Depression commenced in 1929 and continued for most of the 1930s. The collapse of the U.S. economy had a great impact on state revenues and "discouraged investment in the public sector as a whole."⁵²⁶ The decline in state revenue, the national focus on the economy, and the

⁵¹⁷ *Ibid.*, p. 180-181.

⁵¹⁸ Martin, p. 67.

⁵¹⁹ Grob, p. 182.

⁵²⁰ Martin, p. 67.

⁵²¹ Grob, p. 182.

⁵²² *Ibid.*, p. 151.

⁵²³ *Ibid.*, p. 152.

⁵²⁴ *Ibid.*, p. 150-151.

⁵²⁵ *Ibid.*, p. 165.

⁵²⁶ *Ibid.*

tense political situation deteriorating in Europe and Indochina, created the “deterioration of a mental hospital system responsible for an inpatient population that by 1940 approached nearly half a million, the majority of whom were in the chronic category.”⁵²⁷

As the political conflicts in the world became paramount in the late 1930s and erupted into the World War II, the status of the mental hospitals reached a crisis point. The state hospitals were woefully overcrowded and their physical plants were deteriorating from delayed preventive maintenance and renovations due to the lack of adequate funds. The shock therapies seemed to have run their course, and while effective for many patients, for a large number the response was less than desired. A new form of therapy was developed in Europe in 1935 and introduced in the United States the following year. Slowly, it began to catch on in the state mental hospitals as the latest promising new radical treatment: lobotomy.⁵²⁸

The lobotomy was a surgical procedure “that involved severing the nerve fibers of the frontal lobes of the brain.”⁵²⁹ The fundamental premise of the surgery was to “alter underlying abnormal neuron pathways and thus facilitating the reeducation of patients.”⁵³⁰ The psychosurgery, (the euphemism for lobotomy) began to appear in the mental hospitals before World War II. The surgical procedure reached its zenith in 1949 when over five thousand operations were performed in the United States. The procedure was controversial and represented the most radical form of treatment ever developed in the field of psychiatry. But within the context of overcrowded hospitals that were becoming increasingly filled with persons suffering from chronic schizophrenia, (and for whom the other available treatments, including the shock treatments were ineffective) the lobotomy represented another available treatment tool that might hold some hope for success.

Though in time, the shock treatments and the lobotomies would fall out of favor as the preferred course of treatment, in the 1940s the treatments were the cutting edge advancement in psychiatry. The treatments offered hope for thousands of patients and their families who remained afflicted with a chronic mental illness that was seemingly a life sentence to be cared for in a state hospital.

Inpatient Treatment of the Mentally Ill from Post World War II to Present

Ohio’s population continued to grow, and so did the development of its mental hospitals. In the mid 1940s, the Ohio General Assembly enacted legislation that provided for receiving hospitals to be constructed across the state. The receiving hospitals would by virtual of their name, receive patients who were in need of mental health treatment. The goal was to provide the newly admitted patient with intensive services and a greater

⁵²⁷ *Ibid.*

⁵²⁸ *Ibid.*, p. 182-183.

⁵²⁹ *Ibid.*, p. 182.

⁵³⁰ *Ibid.*, p. 183.

staff to patient ratio in the hope that the patient could respond to the treatment and more quickly be discharged back to the community. If this was not possible, the patient would then be transferred to one of the state's mental health institutions that were burgeoning with patients with more chronic cases. Adhering to this mission, the receiving hospitals were designed to have fewer beds and were generally much smaller facilities. Receiving hospitals were built in Youngstown, Cleveland and Cuyahoga Falls. An Army hospital in Cambridge was transferred to the State of Ohio in the late 1940s, and it initially began its function as a receiving hospital.

The populations in the state institutions continued to grow to a peak of 28,663 patients in 1955. The number of patients only begins to tell the story. For many of the patients who remained hospitalized for many years, the hospital had become their new home, and the staff and other patients were their new default family.⁵³¹ Along with this growth was an ever burgeoning Ohio Department of Public Welfare that was responsible for both the operation of these facilities and other support programs. Thus, in 1954, the Ohio General Assembly created a new Department of Mental Hygiene and Correction to operate the state mental health hospitals as well as the institutions for those persons with mental retardation, and the prisons.

On the national scene, the experience of thousands of psychiatrists who had served in World War II and returned home began to reshape the national perspective of mental illness. The psychiatrists had witnessed first hand the effects of combat and other severe forms of environmental stressors on the soldiers. The doctors observed that early treatment resulted in a positive impact on the soldier's condition. They also observed that care provided more closely to where the soldier was located yielded a better prospect for recovery than those who were removed to a more remote location. These observations resulted in a concerted effort by the returning psychiatrists to implement in civilian life what they had learned in military service; and their effort led to a new model in the field of mental health: community psychiatry.⁵³² Concomitant with this new enlightenment was the founding of the National Institute of Health and the passage by Congress of the Hill-Burton Act of 1946.⁵³³ The Hill-Burton Act provided for federal subsidies to spur hospital construction in the post-war economic and political climate. These actions set the stage for the passage of the first National Mental Health act that was signed into law by President Harry S. Truman on July 3, 1946.⁵³⁴

The National Mental Health Act embodied three fundamental goals: 1) support research related to the cause, diagnosis and treatment of mental illness; 2) provide fellowships and grants to stimulate training mental health personnel; 3) award grants to states to establish clinics and other treatment centers, and to promote demonstration studies that would further the national understanding of mental illness and treatment.⁵³⁵ The

⁵³¹ See Appendix B, *Patients are Just People*, by Robert J. Schmidt, for a more personal glimpse into what life was like in the hospitals in the 1960s for one of the patients.

⁵³² Gerald Grob, p. 196.

⁵³³ *Ibid.*, p. 208.

⁵³⁴ *Ibid.*, p. 209.

⁵³⁵ *Ibid.*, p. 210.

National Mental Health Act set the stage for the formation of the National Institute of Mental Health (NIMH) in 1949.⁵³⁶

The initial focus of the National Institute of Mental Health (NIMH) was revealed by noting the projects that received the research money. From 1947 to 1951, NIMH funded 107 research projects. Nearly one-half of these projects were devoted to child personality and development, experimental psychology and neurology, and psychosomatic disorders. Only two projects were devoted to the research of schizophrenia. In terms of real dollars, only 1.5 percent of the funds were devoted to the schizophrenia research projects, while the study of psychosomatic disorders received nearly ten percent of the funding.⁵³⁷ Other significant developments on the national scene that arose during the late 1940's and early 1950's were third-party health insurance and the increasing federal commitment to research, medical technology and specialization within the medical field. All of these developments would have profound and far reaching impact on the treatment of persons with mental illness.⁵³⁸

Mental health treatment options continued to evolve in the post-World War II decade. Milieu therapy and the concept of the therapeutic community gained a strong foothold especially in the state and other psychiatric hospitals.⁵³⁹ Originating in England, the milieu therapy and therapeutic community espoused the hospital staff and patients holding daily meetings wherein the patients gained insights and the staff came to better understand the patients. The basic premise was that "authoritarian hospitals fostered dependency and reinforced the pathological symptoms characteristic of mental disorders...[while] active patient participation in the therapeutic process had beneficial outcomes."⁵⁴⁰ The result was "to change social attitudes in relatively de-socialized patients with severe character disorders, provided they are treated together in a therapeutic community." The hospital environment became "an active force of treatment."⁵⁴¹

Ohio achieved recognition in the advancement of one of the newer psychotherapies. Psychologist Carl Rogers developed his non-directive or supportive therapy that he called, Client-Centered Therapy, in part during his work as a professor at The Ohio State University in the early 1940s. Psychologist Robert Bles developed scenario role therapy during his work at the Columbus State Hospital in 1951.⁵⁴²

Another significant development was the advent of psychotropic medications designed to ameliorate the symptoms of the mental disorders. Heretofore, medications had been used to either induce convulsions as part of shock therapy, or in the 18th and early 19th centuries to facilitate purging. The first major drug to be approved and marketed in the

⁵³⁶ *Ibid.*, p. 211.

⁵³⁷ Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America*, Princeton, N.J.: Princeton University Press, 1991, p. 67.

⁵³⁸ Grob, *Mad Among Us*, p. 208.

⁵³⁹ *Ibid.*, p. 226.

⁵⁴⁰ *Ibid.*, p. 227.

⁵⁴¹ *Ibid.*, p. 226.

⁵⁴² Robert Schmidt, written historical account while at Columbus State Hospital, undated.

United States as a tranquilizer was chlorpromazine, more commonly known by its brand name, Thorazine. The drug had been under development and trials in Europe for a decade or so before its introduction in the states. At nearly the same time, Reserpine (Serpasil) gained prominence as another tranquilizer. Imipramine (Tofranil) and Iproniazid (Iprozid) were subsequently introduced to combat depressive symptoms.⁵⁴³ These new drugs were met with a cautious reception. Early results seemed very encouraging and many wondered whether the new drugs would usher in another revolution in psychiatry.⁵⁴⁴ Other mental health professionals were more reserved and cautioned that the drug therapies would be just the latest therapy that was “hailed as opening a ‘new era’ in psychiatry, hailed by some, even, as a ‘cure’ for mental disease, only to be discarded as a cure and retained as a palliative.”⁵⁴⁵ In time, the observation of adverse side effects and concerns over long term effects would dampen the enthusiasm for the new drugs. But what seemed to be clear was that the mental health field was finally onto something meaningful, that something being a renewed optimism that mental illness could be effectively treated. If the new drugs could ameliorate the major symptoms so that the patient was more receptive to milieu or other psychotherapies, there was the possibility of ending the cycle of long term psychiatric hospitalizations.

A revised federal public policy on mental health begged for consideration. The new federal public policy which was supported by all the state governors, affirmed the need to rebuild the state mental hospitals after decades of neglect, construct new facilities to alleviate the overcrowded conditions and provide for specialized populations such as children, and adults who suffered from substance abuse or sexual deviancy. At the same time, the new policy affirmed the value of community based treatment and prevention programs.⁵⁴⁶ In all states, larger expenditures were approved by state legislatures for construction of these facilities.

The community mental health movement began at the state level. Led by New York and California in the mid-1950's, the other states moved in the direction of promoting and funding programs that treated persons with mental illness while they were still residing in the community.⁵⁴⁷

At the same time, at the federal level, in 1955 Congress passed and President Dwight Eisenhower signed into law, the Mental Health Study Act. The Mental Health Study Act led to the development of the Joint Commission on Mental Illness.⁵⁴⁸ The Joint Commission on Mental Illness was charged with the task to study mental illness with the focus on “medical, psychological, social, economic, cultural and other factors that relate to etiology,” develop improved methods for the diagnosis and treatment of the mentally ill and mentally retarded, evaluate and improve the recruitment and training of mental

⁵⁴³ *Ibid.*, p. 228-229.

⁵⁴⁴ Martin, p. 65.

⁵⁴⁵ *Ibid.*, p. 67.

⁵⁴⁶ Grob, p. 231

⁵⁴⁷ *Ibid.*, p. 234-235.

⁵⁴⁸ *Ibid.*, p. 241-242.

health personnel and conduct a national survey to assist in the development of a “comprehensive program.”⁵⁴⁹ The Commission spent the remainder of the 1950’s completing its tasks. The significant findings were “the belief that the pervasiveness of psychological and environmental stress mandated an expansion of therapeutic services in both institutions and communities; that early interventions would prevent the onset of more serious disorders; that the efficacy of social and psychological therapies was a matter of fact...that a concerted attack on the prevalence of psychological disturbances and mental illnesses required the creation of a broad-based coalition of professional and lay groups.”⁵⁵⁰ The final report of the Commission was entitled, *Action for Mental Health*.

The *Action for Mental Health* report was released in March, 1961 shortly after a new administration occupied the White House. President John F. Kennedy’s administration was felt to be more supportive of the need to implement the recommendations embodied in the report.⁵⁵¹ The *Action for Mental Health* report recommended:

- 1) large investments in eclectic research including an expansion of the educational and research involvement of the National Institute of Mental Health;
- 2) a national recruitment and training program with an expanded “liberal philosophy” of treatment designed to eliminate staff shortages and minimize professional turf issues;
- 3) one community clinic for each 50,000 population to be supplemented by general hospital psychiatric facilities and regional treatment centers;
- 4) no more state hospitals be constructed that were planned to have more than 1,000 beds; the state hospitals that had less than 1,000 beds were to reorganized into treatment centers for the care of persons who had long term and/or chronic diseases including mental illness.
- 5) Aftercare and rehabilitation be integrated with the other array of services to reduce the need for hospitalization or readmission.
- 6) The dissemination to the public of information about mental illness and mental health treatment and thereby reduce the effects of stigma and the sense of “defeatism” that stymied the administration of effective treatments.
- 7) Federal funding be doubled in five years and tripled in ten years in order to support the other recommendations.⁵⁵²

If the recommendations of the *Action for Mental Health* were enacted into law, the Joint Commission predicted the law would “revolutionize public care of persons with major mental illness—the nearly 1,000,000 patients who pass through State hospitals and community mental health clinics each year.”⁵⁵³ The next move was up to the Kennedy Administration. The new President created an interagency task force to consider the recommendations. At the same time, the National Institute of Mental Health (NIMH)

⁵⁴⁹ *Ibid.*, p. 242.

⁵⁵⁰ *Ibid.*, p. 243-244.

⁵⁵¹ *Ibid.*, p. 245.

⁵⁵² *Ibid.*, p. 246-247.

⁵⁵³ *Ibid.*, p. 248.

moved forward on policy recommendations of its own. The NIMH proposed the creation of comprehensive centers “which would serve a designated population within a specific geographical area.”⁵⁵⁴ After considering the NIMH proposal, the President’s interagency task force signed on with the NIMH policy recommendation.

Thanks in large part to the efforts of Ohioan Anthony J. Celebrezze, Sr., who served as President Kennedy’s Secretary of Health, Education and Welfare, support grew in Congress for the centers which were now being termed, comprehensive community mental health centers. Secretary Celebrezze, Sr. envisioned that the community mental health centers would replace the traditional institutions, i.e. state hospitals. Secretary Celebrezze, Sr. stated that community mental health centers should be:

“...the foci of future mental health activities. They would be close to the patient’s home, and would provide preventive, early diagnostic, and outpatient and inpatient treatment, and transitional and rehabilitation services. They would include psychiatric units in general hospitals, thereby providing the patient with the opportunity of being treated within his community environment. These facilities would be conveniently located in population centers and could provide patients with a continuity of care not now available. As his needs change, the patient in such a center could move quickly to appropriate services such as those for diagnosis, treatment, and rehabilitation; inpatient, outpatient, day or night programs; foster care, sheltered workshop, and industry.”⁵⁵⁵

The financing for the comprehensive community mental health centers would be a joint effort with the state, local government and the private sector covering the operating costs. The construction expenditures would be managed in a way similar to the Hill-Burton Act provisions. The passage of the bill was hardly a foregone conclusion, but the proponents worked diligently to rally the political support necessary to achieve passage. Finally overcoming all major opposition, including a charge from the American Medical Association that the federal funding to assist with start up operating costs was moving towards ‘socialized medicine,’ the bill was signed into law on October 31, 1963 by President John F. Kennedy.⁵⁵⁶

The new law was entitled, The Mental Retardation and Community Mental Health Centers Construction Act of 1963. Each state was required to submit a comprehensive plan which included designating the state government entity that would oversee the program. The final bill provided for the maximum community population that each new center would provide services. What the new law failed to require was any mandated linkage between the new community mental health centers and the state hospitals. It would be up to the states to assure that continuity of care issues were addressed.⁵⁵⁷

The assassination of President Kennedy just three weeks following final passage was a temporary set back to the implementation of the new law. However, his successor,

⁵⁵⁴ *Ibid.*, p. 254.

⁵⁵⁵ Anthony Celebrezze, et al. to President John F. Kennedy, November 30, 1962, White House Central Files, Box 338, Folder HE 1-1, John F. Kennedy library quoted by Dr. Grob, p. 255.

⁵⁵⁶ Grob, p. 257.

⁵⁵⁷ *Ibid.*, p. 260.

President Lyndon B. Johnson adopted the direction of the new law as part of his Great Society program. In 1965 the final provisions of the new law were in place with the passage of the bill that authorized federal grants to assist with staffing the mental health centers.⁵⁵⁸ As part of President Johnson's Great Society, two significant amendments were added to the Social Security Act of 1935. The two amendments were Medicare and Medicaid. Title 18 amendment (Medicare) provided in two parts hospital insurance and physician and other medical services care for the aged. Title 19 (Medicaid) was comprised of grants to states to encourage them to develop medical assistance programs for the impoverished citizens in their states.⁵⁵⁹ With the Community Mental Health Centers Construction Act, the two major amendments to the Social Security Act and the passage of Civil Rights Acts of 1964 and 1968, the country seemed poised to achieve the great society that President Johnson envisioned. However, the escalation of the war in Vietnam diverted the attention of the country and redirected the priority for the federal financial resources.

With respect to the implementation of the Community Mental Health Centers Construction Act, the building of the new mental health centers across the country took place at a much slower pace than originally planned. Equally troubling was the focus of the new community mental health centers on caring for persons with "emotional disturbances" rather than the more severe mental illnesses.⁵⁶⁰ For example, nationally, the persons with major mental disorders such as depression and schizophrenia comprised only thirty-nine per cent of those treated at the community mental health centers in 1970. Four years later, the percentage had dropped even lower to twenty-four percent. At the same time, persons with "social maladjustments" comprised initially fewer than five percent of all persons seen at the mental health centers in 1970. Four years later, the diagnosis was given to one-fifth of all persons treated at the centers.⁵⁶¹ What seemed to be developing was a dichotomy of parallel systems; the community mental health centers for primarily the less severe cases and the continuation of the state hospital system for the more seriously mentally ill patients.⁵⁶²

A significant provision of the Medicare and Medicaid amendments directly impacted on the composition of the patients in the state hospitals. The amendments were written to restrict these benefits to persons who were cared for at treatment settings other than the state hospitals. Most state hospitals were designated as Institutions of Mental Diseases (IMD) and the majority of patients receiving care in these state run facilities were generally ineligible for Medicare and Medicaid benefits. The federal IMD rule served as a not so subtle incentive for the states to discharge the chronically ill aged people who comprised a large percentage of the state hospital population to nursing homes where they could receive "far more generous federal payments."⁵⁶³ The drop in the percentage of chronically ill aged persons in the state hospitals across the nation

⁵⁵⁸ *Ibid.*, p. 261.

⁵⁵⁹ *Ibid.*, p. 265.

⁵⁶⁰ *Ibid.*, p. 263.

⁵⁶¹ *Ibid.*

⁵⁶² *Ibid.*, p. 264.

⁵⁶³ *Ibid.*, p. 266.

was startling. In just a decade from 1962 to 1972, the national percentage of chronically ill aged in state hospitals dropped forty-nine percent, while the entire populations in state hospitals declined by forty-six percent.⁵⁶⁴ At the same time, the number of aged persons cared for in nursing homes nearly doubled.⁵⁶⁵

Nationally, the decline in the number of persons hospitalized in state and county mental hospitals was contrasted by a startling increase in the number of admissions. For example, in 1950 there were over a half million patients in the hospitals (512,501) and just two decades later by 1971 that number declined to just over three hundred thousand (308,983),⁵⁶⁶ a decline of forty percent. During the same period of time, admissions increased from 152,286 in 1950 to 402,472 in 1971,⁵⁶⁷ an increase of 164 percent!

Also noteworthy was the even more dramatic increase in discharges than admissions; from 99,659 discharges in 1950 to 405,681 in 1971, an increase in discharges of 307 percent. Clearly, a change in the composition of the patients treated in the state hospital was taking place across the nation. More patients were being discharged than admitted. The lengths of stay were declining as well. Due to the reduced length of stay, and a younger and healthier patient population, deaths were also declining. The number of deaths also dropped from 41,280 to 26,835 during the same time period.⁵⁶⁸

While the deinstitutionalization process of the state hospitals that began in the late 1960s was due in part to the new psychotropic drugs and other therapies that were being developed and to a lesser extent due to the gradual development of the community mental health centers, a significant factor was the shifting of the aged persons from one institution (the mental hospitals) to another institution (nursing homes). Whether ultimately this intended outcome was the best for all concerned was open for discussion, but what was apparent was that the makeup of the state hospital patient population would be permanently altered.

Private entrepreneurs, divining an opportunity, came on the scene and developed inpatient programs as part of the growing community mental health movement. The 1950s and 60s saw a marked increase in the number of private mental health hospitals. Much of this development was spurred by the Hill Burton Act as well as the incentives for payments by Medicare, Medicaid and private insurance in the mental health treatment arena. Unlike the state hospitals that were designated IMDs and thus the patients were ineligible for Medicare and Medicaid benefits, the patients treated in the private hospitals could continue to receive their federal benefits and have their hospitalization paid for in part by these benefits. The growth of the private hospitals was so pronounced that by the mid-1970s more patients were admitted to the private hospitals than the state-operated institutions.

⁵⁶⁴ Ibid.

⁵⁶⁵ Ibid.

⁵⁶⁶ Grob, *From Asylum to Community: Mental Health Policy in Modern America*, p. 260.

⁵⁶⁷ Ibid.

⁵⁶⁸ Ibid.

In July, 1967, the Ohio General Assembly passed House Bill 648 that created county and multi-county boards for mental health and mental retardation. The thrust of the legislation was to empower local authorities for the development of community based mental health treatment. The act was an acknowledgement of the significant role that local authorities could assume in evaluating their community needs and planning for local mental health services. The intent was to realize a reduction in the number of persons who would need to be hospitalized through the development of community based programming by local authorities. The county mental health boards would serve as the community mental health planning agency for the county or counties under its jurisdiction, "and in so doing it shall:

- (a) Evaluate the need for facilities and community mental health services;
- (b) In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations, assess the community mental health needs, set priorities, and develop plans for the operation of facilities and community mental health services;
- (c) ...develop and submit to the department of mental health... a community mental health plan listing community mental health needs, including the needs of all residents of the district now residing in state mental institutions and severely mentally disabled adults, children, and adolescents...⁵⁶⁹

The county mental health board law also proposed for the first time since 1835, a partnership between the state and county mental health authorities. But this time, the authorities would be the county mental health boards and the Department of Mental Health.

The increasingly complex role of state operated services called for the further refinement of the role of state human service departments. The Department of Rehabilitation and Corrections assumed exclusive responsibility for the correctional facilities. The Department of Mental Retardation and Developmental Disabilities acquired responsibility for those facilities. The Department of Mental Health was created to exclusively operate the mental health institutions and also oversee the community based treatment development.

Concomitant with these advances, an examination of patients' rights gained momentum across the United States. Civil commitment laws were challenged as too vague, arbitrary, and capricious in interpretation. The commitment process was alleged to lack due process. Once hospitalized, patients were affirmed as maintaining certain rights, including the right to treatment, the right to refuse treatment, confidentiality, and the right to treatment in the least restrictive treatment environment. As a result of the patients' rights movement, a long over due rewriting of legislation of mental health laws took place in many states, including Ohio.⁵⁷⁰ The first significant revisions to the Ohio's

⁵⁶⁹ Ohio Revised Code, § 340.03

⁵⁷⁰ Grob, *The Mad Among Us*, p. 274.

civil commitment laws were enacted in 1976 and since then timely revisions have been made.⁵⁷¹

Spurred on by the renewed attention on mental health legislation and patient's rights, the Ohio General Assembly established the Ohio Legal Rights Service in 1975. The Ohio Legal Rights Service was designed to be an independent state agency whose mission was to advocate for persons with disabilities.⁵⁷² Ohio Legal Rights Service was designated in 1980 to serve as the state's Protection and Advocacy agency under the federal Developmental Disabilities Act of 1973.⁵⁷³

Also during the 1970s, federal support for mental health funding came under close scrutiny by President Richard M. Nixon's administration. The Nixon Administration sought to reduce funding for the National Institute of Mental Health and also attempted to terminate funding for the Community Mental Health Centers Act, alleging that the program was only intended as a demonstration and not as an ongoing national direction. The matter was finally settled in the courts in favor of the continuation of funding.⁵⁷⁴

The U.S. Congress did call for an evaluation of the community mental health center program. Two of the key findings were that the system as implemented so far failed to provide a coordinated delivery of services and that there was a "lack of working relationship between mental hospitals and centers."⁵⁷⁵ The result was a 1975 federal mental health law that required twelve mandated services incorporated with the original five services. The new services required mental health screening, follow up care, specialized services for children and elderly adults as well as alcohol and substance abuse services. Although President Nixon vetoed the legislation, the Congress overrode his veto by one vote. Tenuous federal support for expanded mental health services was assured, at least for the time being.⁵⁷⁶

When President Jimmy Carter came into office in 1977, his administration infused new life into the national focus on mental health in the mid-1970s. First Lady Rosalynn Carter spearheaded the President's Commission on Mental Health. A key finding was that nationally, the mental health programs were seen as "moving away" from the treatment of persons who were the most severely mentally ill, that is, the individuals who were more likely to be hospitalized in a state hospital.⁵⁷⁷ The commission drafted language that made its way belatedly through the U.S. Congress in 1979. The new federal act, known as the Mental Health Systems Act of 1980 provided for continued federal funding, increased support for vulnerable groups, improved planning, accountability and performance measures, linkage between mental health and general

⁵⁷¹ Ohio Revised Code Chapter 5122.

⁵⁷² Ohio Legal Rights Service web site.

⁵⁷³ *Ibid.*

⁵⁷⁴ Grob, p. 282.

⁵⁷⁵ *Ibid.*, p. 283.

⁵⁷⁶ *Ibid.*

⁵⁷⁷ *Ibid.*, p. 285.

medical care, and increased protection of patient's rights.⁵⁷⁸ At the federal level, public mental health had a new direction and a renewed commitment. But mental health funding and policy cannot exist in a political vacuum. Economic woes at home and the Iranian hostage crisis altered the political environment leading to the election in the fall of 1980. A new direction in the country was called for by the electorate and thus, Ronald Reagan was elected the next president.

President Ronald Reagan's administration immediately sought to reverse the national mental health policy. National funding for mental health services was cut by twenty-five percent and rather than fund the wide array of programs, the Reagan Administration converted the mental health programs into single block grants to the states. The 1981 Omnibus Budget Reconciliation Act repealed a great many of the provisions in the 1980 Mental Health Act. President Reagan sought to diminish the federal influence on mental health funding and policy, preferring for the states and local governments to assume the greater responsibility. Thus, for the first time since pre-World War II, the federal government influence in mental health programming diminished.⁵⁷⁹ The most significant adverse result was the decision by the Reagan Administration to deny literally thousands of disabled persons' claims for supplemental security income (SSI) and to deny continued benefits of Social Security Disability Income (SSDI). Persons with severe mental illnesses were particularly targeted. Even though these persons only comprised eleven percent of all persons receiving SSDI, they comprised thirty percent of those whose SSDI benefits were cut.⁵⁸⁰ Public outcry mounted, and in 1983 the Reagan administration reversed its policy.

In the late 1980's several advances on the national scene helped to elevate the concept of community based care. Initially launched in 1977 by the National Institute of Mental Health, the Community Support Program received modest funding at the outset. However, by 1987, funding had increased fivefold thanks to the U.S. Congress enactment in 1984. The joint federal and state funded partnership was designed to provide for the needs of the severely mentally ill in the community. The Community Support Program had ten components that reflected the growing understanding of the pervasiveness of mental illness on all aspects of one's life. The components included "housing, income, psychiatric and medical treatment, and supportive services."⁵⁸¹ In 1986, the State Comprehensive Mental Health Services Act further reinforced support for this new approach to caring for persons with persistent mental illnesses in their communities.

The effectiveness of the Community Support Program approach was demonstrated in several longitudinal studies. Especially promising were the community mental health programs developed in Madison, Wisconsin and headed by Leonard Stein and Mary Ann Test. The Training in Community Living Project demonstrated the efficacy of providing aftercare services to discharged patients who had been hospitalized for an

⁵⁷⁸ *Ibid.*, p. 286.

⁵⁷⁹ *Ibid.*

⁵⁸⁰ *Ibid.*, p. 301.

⁵⁸¹ *Ibid.*, p. 305.

extended period of time. The findings suggested that persons with severe mental illnesses could be effectively cared for in the community.⁵⁸² Courtney Harding and others demonstrated in a landmark longitudinal study conducted in Vermont that persons with chronic severe mental illnesses could benefit from community based rehabilitative services. Their study showed improvement in from one-half to two-thirds of the cases.⁵⁸³ Although the cost of this community support treatment was expensive, the disbursement was still well below the cost for inpatient hospitalization.

The Community Support Model received a significant boost when the Robert Wood Johnson Foundation created the Program on Chronic Mental Illness in 1985. Nine cities across the country received funding to deliver services to chronically mentally ill persons. Ohio was fortunate that three of the grants went to cities in the Buckeye state: Cincinnati, Columbus, and Toledo.⁵⁸⁴ In the case of Ohio projects, the centralized authority was the county ADAMHS board rather than a city government entity. The intent of the grants was to demonstrate that a central authority in charge of planning and the delivery of services could benefit persons with chronic and persistent mental illnesses. The project outcomes gave support that such an initiative could have some success in that a central authority was more likely to see how the entire system served the needs of its entire constituents rather than be limited by the province of an individual treatment program.⁵⁸⁵ The central authority was seen as a way to improve financial support for programming and where system change could be accomplished.

While significant advances were being made in mental health laws and the development of community based services, the state run mental hospitals continued to serve a significant, albeit reduced number of patients. The problem was these services were being provided in many facilities that were constructed in the nineteenth century and would require significant and expensive renovation to bring up to present life and safety codes. The facilities had suffered from the neglect of preventative maintenance and updates since the decline in state funding during the Great Depression. The federal Medicaid and Medicare programs were intentionally designed to encourage states in the direction of community based care. The federal government concluded that states were not progressive enough in their planning for mental health services. The states were perceived as still holding onto their institutions that were clearly outdated.⁵⁸⁶

Thus the states, including Ohio, found themselves faced with significantly mounting maintenance and operational costs to maintain the facilities that further eroded the state budgets. A major step forward in improving Ohio's state hospitals resulted from House Bill 1215 in 1978. The new law required Joint Commission on Accreditation of Hospitals accreditation for all ODMH run facilities. The life and safety standards were considered especially significant as the standards resulted in an evaluation of the existing facilities.

⁵⁸² *Ibid.*, p. 306-307.

⁵⁸³ Harding, C. M., Brooks, G. W., Asolaga, T. S. J. S., and Breier, A. (1987). *The Vermont longitudinal study of persons with severe mental illness*. *American Journal of Psychiatry*, 144, 718-726.

⁵⁸⁴ Grob, p. 307-308.

⁵⁸⁵ *Ibid.*, p. 308.

⁵⁸⁶ *Ibid.*, p. 281.

Rather than invest significant funds to make the necessary improvements to bring the old facilities up to current life and safety code standards, ODMH opted instead to develop a program to replace the old facilities with new and smaller buildings that would be in line with present life and safety codes, more efficient to run, and also embody many of the treatment advances in the inpatient care of persons with mental illness. The design and construction of these new facilities would take time and come at a great expense; but at least the direction was set.

By the late 1980s the number of patients in the Ohio state operated hospitals was consistently declining to fewer than twelve hundred patients. At the same time, the cost for providing the care and maintenance of the facilities continued to rise. With limited funds available for both state operated care and the ever increasing community based programs, the system of care was under considerable financial strain.

In 1988, ODMH Director Pamela S. Hyde spearheaded an innovative plan to address the long term funding needs of the now complex state mental health system of care. Through her leadership, the Mental Health Act was signed in law by Governor Richard Celeste. The tenets of the Mental Health Act of 1988 were to move toward community based treatment instead of institutional care, and to evolve towards local control over mental health planning and funding. The innovative law launched Ohio to the forefront of mental health care in the country. The Mental Health Act provided that over a period of years, the mental health boards would receive greater control over the funding that was set aside for the operation of the state run hospitals. At the same time, the mental health boards would then purchase a projected amount of bed days at the state hospitals. The purchased beds days would then be used by ODMH to fund the operation of the hospitals. The state funds that the local ADAMHS boards did not need to purchase bed days would then be available for improving community based services. Certain forensic status clients were excluded from the ADAMH Boards bed days purchasing as their care was to remain a responsibility of ODMH. By 1990, Ohio was ranked as having the fourth best system of mental health care, a jump from being ranked twenty-sixth just four years previously.

Director Michael F. Hogan guided Ohio's system of mental health care through the major implementation of the Mental Health Act. One of the key developments was the Inpatient Future Working Groups across the state that looked at the future. The Inpatient Future Working Groups brought together key stakeholders at the state and local level to consider the future inpatient needs in the state. These groups recommended that regional planning Collaboratives be established to guide the future development of mental health services.

Simultaneous with the advances in innovative mental health funding was the clinical and treatment promise for improved outcomes created by the development of second generation anti-psychotic medications in the mid-1990s. Anti-psychotic drug research had been continually underway to develop newer drug(s) that would hold the greater potential to reduce negative symptoms of schizophrenia and not have the common unpleasant extrapyramidal side effects and permanent tardive dyskinesia symptoms

often associated with the first generation of anti-psychotic medications. The first generation anti-psychotics included: haloperidol (Haldol), phenothiazines (Thorazine, Prolixin, Trilafon, Stelazine, etc.) and thioxanthenes (Navane). The second-generation anti-psychotics, also referred to as the atypical anti-psychotics, included Clozapine (Clozaril), Olanzapine (Zyprexa), Risperidone (Risperdal), Quetiapine (Seroquel), Ziprasidone (Geodon), Amisulpride (Solian), and Paliperidone (Invega). The second generation anti-psychotic medications were heavily marketed by their manufacturers.

The strong promotion effort coupled with the pharmaceutical industry's own studies that purported greater efficacy and reduced side effects, the second generation anti-psychotics quickly gained a major market share of all anti-psychotic medications. At the beginning of the twenty-first century, the second generation anti-psychotics comprised nearly ninety percent of the market share.⁵⁸⁷ Along with the increased market share was a burgeoning of the costs of anti-psychotic medications in the United States.⁵⁸⁸ An increasing percentage of mental health dollars were devoted to pay for these new anti-psychotics which were protected by patent, and thus their manufacturer could control the price charged for the medication.⁵⁸⁹

Expenditures for prescription drugs had grown from comprising just seven percent of all mental health expenditures in 1986 to twenty-three percent in 2003. Forecasts noted that this increase in the percentage of mental health expenditures was likely to continue to where by 2014 it was predicted that prescription drug costs will account for thirty percent of all mental health expenditures.⁵⁹⁰ The increase in costs of mental health prescription drugs, i.e. second generation anti-psychotic medications was so significant that the increased cost had a marked increase in overall healthcare prescription costs as well. From 1986 to 2003, the mental health prescription drugs costs accounted for a fourteen percent increase in the overall healthcare prescription costs. The forecast is that from 2003 to 2014, the mental health prescription costs will comprise eleven percent of the overall healthcare prescription costs.⁵⁹¹

A significant motivation for the pharmaceutical companies to develop and aggressively market the new second generation anti-psychotic medication was due to the fact that nearly all the first generation anti-psychotic medications had by now gone off-patent and were now available in generic form at a significantly reduced cost. The pharmaceutical companies saw the opportunity to develop and promote the second generation anti-psychotic medications as a way to bolster their revenue.

⁵⁸⁷ Jeffrey Lieberman, *et.al.* "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia" in *The New England Journal of Medicine*, Vol. 353:1209-1223, September 22, 2005.

⁵⁸⁸ *Ibid.*

⁵⁸⁹ Katharine R. Levit, *et. al.* Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014, SAMHSA Publication No. SMA 08-4326. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008, p. 22.

⁵⁹⁰ *Ibid.*

⁵⁹¹ *Ibid.*, p. 23.

The wide acceptance of the second generation anti-psychotic medications was bolstered by the development of a clinical decision tree for physicians. The Texas Medication Algorithm Project (TMAP) was developed in 1996 and quickly gained wide spread acceptance by clinicians to use in determining the medication choices in the treatment of persons with major mental illnesses.⁵⁹² For the treatment of an initial episode of schizophrenia, the TMAP called for a trial of a single second generation anti-psychotic medication. If the patient's response was partial or no response at all, the second stage called for a trial of another second generation anti-psychotic medication or a first generation anti-psychotic medication.⁵⁹³ If the patient's response remained less than desired, in subsequent stages the physician could prescribe a combination of first and second generation anti-psychotics. Clozapine, another second generation anti-psychotic could also be considered for inclusion in the patient's treatment regimen.⁵⁹⁴

Initially, the pharmaceutical companies' own funded research held out promise for the efficacy of the second generation anti-psychotic medications. However, as more patients were prescribed the medications and clinicians acquired more experience with the medications, untoward side effects and other dangerous conditions came to light. Clozapine was found to possibly cause a serious condition known as agranulocytosis (decrease in white blood cells) that required close monitoring with at least weekly blood analysis. Olanzapine (Zyprexa) was increasingly associated with marked weight gain and altered glucose and lipid metabolism⁵⁹⁵ resulting in increased risk of diabetes mellitus. With these concerns being raised as well as the high cost of the medications, renewed questions were "raised about the clinical advantages and cost effectiveness of the atypical drugs."⁵⁹⁶ What was needed was an objective and independent research study to examine the efficacy of the second generation anti-psychotic medication. In 2001, the National Institute of Mental Health (NIMH) commissioned an exhaustive and rigorous research known as the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. The CATIE would take nearly four years to complete.

In 2005, the National Institute of Mental Health published the results of CATIE study in the *New England Journal of Medicine*, entitled, "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia."⁵⁹⁷ The study compared the efficacy and safety of the second generation anti-psychotic medications: Seroquel, Risperdal, Geodon, and Zyprexa with Trilafon, a first generation anti-psychotic medication that was selected "because of its low potency and moderate side effect profile."⁵⁹⁸ The double blind study involved fifty-seven clinical sites across the country including in Ohio, the University of

⁵⁹² <http://www.dshs.state.tx.us/mhprograms/TMAPover.shtml>

⁵⁹³ <http://www.dshs.state.tx.us/mhprograms/pdf/TIMASCZAlgoAlgorithm.pdf>

⁵⁹⁴ *Ibid.*

⁵⁹⁵ Jeffrey Lieberman, *et.al.* "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia," in *The New England Journal of Medicine*, Vol. 353:1209-1223, September 22, 2005, Number 12.

⁵⁹⁶ *Ibid.*

⁵⁹⁷ *Ibid.*

⁵⁹⁸ *Ibid.*

Cincinnati Medical Center and Appalachian Psychiatric Healthcare System, Athens campus.⁵⁹⁹ The results of phase one of the four year study were:

“In summary, patients with chronic schizophrenia in this study discontinued their antipsychotic study medications at a high rate, indicating substantial limitations in the effectiveness of the drugs. Within this limited range of effectiveness, olanzapine [Zyprexa] appeared to be more effective than the other drugs studied, and there were no significant differences in effectiveness between the conventional drug perphenazine [Trilafon] and other other second-generation drugs. There were no significant differences among the drugs in the time until discontinuation of treatment owing to intolerable side effects...[olanzapine’s] apparent superior efficacy is also indicated by the greater reduction in psychopathology, longer duration of successful treatment, and lower rate of hospitalizations for an exacerbation of schizophrenia. The results of the other second generation antipsychotic agents and the representative conventional drug, perphenazine, were similar in most respects. It is important to note that the differences between olanzapine and perphenazine were moderate...”⁶⁰⁰

While the CATIE study identified the above advantages of olanzapine [Zyprexa], the study cautioned that “olanzapine was associated with greater weight gain and increases in glycosylated hemoglobin, cholesterol, and tri-glycerides, changes that may have serious implications with respect to medical co-morbidity such as the development of the metabolic syndrome.”⁶⁰¹ The study postulated that, “How clinicians, patients, families and policymakers evaluate the trade-offs between efficacy and side effects, as well as drug prices, will determine future patterns of use.”⁶⁰² Managed care entities were already “restructuring drug insurance benefits that encourage consumers to purchase lower cost generic drugs rather than branded products that require higher cost-sharing.”⁶⁰³

Another significant achievement in the treatment of persons with mental illness occurred in the mid-1990s. On the national level, efforts were made to achieve health insurance coverage for mental illnesses on par or with parity with those of other behavioral health issues. The federal Mental Health Parity Act of 1996 (MHPA) addressed two types of insurance coverage: 1) Large group self-funded group health plans; 2) Large group fully insured group health plans.

The key component of the MHPA was that a large group health plan was prevented “from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.”⁶⁰⁴ The Mental Health Parity Act did have several major drawbacks: 1) The law provisions did not apply to small group health plans or individual

⁵⁹⁹ Ibid.

⁶⁰⁰ Ibid.

⁶⁰¹ Ibid.

⁶⁰² Ibid.

⁶⁰³ Katharine R. Levit, et al. Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004-2014, SAMHSA Publication No. SMA 08-4326. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008, p. 23.

⁶⁰⁴ “Mental Health Parity Act of 1996”, Center for Medicare and Medicaid Services, cms.hhs.gov.

health insurance coverage; 2) large group health plans could impose some restrictions on mental health benefits and still comply with the law. For example, the restrictions could include covering mental health services within network only, increasing co-payments or limiting the number of visits for mental health benefits; imposing limits on the number of covered visits, even if the plan does not impose similar visit limits for medical and surgical benefits; and different cost-sharing arrangements, such as higher coinsurance payments for mental health benefits.⁶⁰⁵ Nonetheless, the Mental Health Parity Act of 1996 was the all important first step on the path to achieving equality for mental health benefits.

In 1999, the national mental health movement received a boost with the first ever Surgeon General's Report on mental health issues. Surgeon General David Satcher's report entitled *Mental Health: A Report of the Surgeon General*, set forth the theme that mental health and mental illness are public health issues.⁶⁰⁶ A related theme was the mind and the body are inseparable entities, and as a result, the physical health and mental health fields grew more closely allied. The report emphasized research findings and best practices. The Report concluded with the Surgeon General's Vision for the Future. The Surgeon General offered the following directions:

- 1) Continue to build the science base with special emphasis on "evidence which supports strategies for mental health promotion and illness prevention."⁶⁰⁷
- 2) Overcome Stigma "by dispelling myths about mental illness, by providing accurate knowledge to ensure more informed consumers, and by encouraging help seeking by individuals experiencing mental health problems."⁶⁰⁸
- 3) Improve Public Awareness of Effective Treatment through encouraging "all human service professionals...to be better informed about mental health treatment resources in their communities."⁶⁰⁹
- 4) Ensure the Supply of Mental Health Services and Providers by expanding "the supply of effective, evidence-based services throughout the Nation."⁶¹⁰
- 5) Ensure Delivery of State of the Art Treatments by translating into community settings the "wide variety of effective, community-based services...carefully refined through years of research."⁶¹¹

⁶⁰⁵ Ibid.

⁶⁰⁶ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, p. 3.

⁶⁰⁷ Ibid., p. 22.

⁶⁰⁸ Ibid.

⁶⁰⁹ Ibid.

⁶¹⁰ Ibid.

⁶¹¹ Ibid.

6) Tailor Treatment to Age, Gender, Race and Culture by promoting “Culturally competent services” through “appropriate training and a fundamental respect for clients” and “the need to redress the current insufficient supply of mental health professionals who are members of racial and ethnic minority groups.”⁶¹²

7) Facilitate Entry into Treatment “through the multiple ‘portals of entry’ that exist: primary health care, schools, and the child welfare system.” The Report highlighted that “assuring the small number of individuals with severe mental disorders who pose a threat of danger to themselves or others ready access to adequate and appropriate services promises to reduce significantly the *need* for coercion in the form of involuntary commitment to a hospital and/or certain outpatient treatment requirements that have been legislated in most states and territories. Coercion should not be a substitute for effective care that is sought voluntarily; consensus on this point testifies to the need for research designed to enhance adherence to treatment.”⁶¹³

8) Reduce Financial Barriers to Treatment by providing “equality between mental health coverage and other health coverage—a concept known as parity...an affordable and effective objective.”⁶¹⁴

Four years later in 2003, President George W. Bush’s New Freedom Commission on Mental Health built upon the findings and recommendations of the 1999 Surgeon General’s Report. The New Freedom Commission, chaired by Ohio’s Department of Mental Health Director, Dr. Michael F. Hogan, entitled their report: *Achieving the Promise: Transforming Mental Health Care in America*.⁶¹⁵ The Commission’s report highlighted six major goals with a series of recommended strategies to help achieve each goal. The six goals and recommendations were:

1) Americans Understand that Mental Health is Essential to Overall Health. The recommendations were to: a) “advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.” b) Address mental health with the same urgency as physical health.”⁶¹⁶

2) Mental Health Care is Consumer and Family Driven. The recommended strategies were: a) “Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance;” b) “Involve consumers and families fully in orienting the mental health system toward recovery;” c) “Align relevant Federal programs to improve access and accountability for mental health services;” d)

⁶¹² Ibid., p. 23.

⁶¹³ Ibid.

⁶¹⁴ Ibid.

⁶¹⁵ Hogan, Michael, et al. President’s New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America*, 2003.

⁶¹⁶ Ibid., p. 17.

Create a Comprehensive State Mental Health Plan;” e) “Protect and enhance the rights of people with mental illnesses.”⁶¹⁷

3) Disparities in Mental Health Services are Eliminated. The recommendations were: a) “Improve access to quality care that is culturally competent;” b) “Improve access to quality care in rural and geographically remote areas.”⁶¹⁸

4) Early Mental Health Screening, Assessment, and Referral to Services are Common Practice. The recommended strategies included: a) “Promote the mental health of young children;” b) “Improve and expand school mental health programs;” c) “Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies;” d) “Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.”⁶¹⁹

5) Excellent Mental Health Care is Delivered and Research is Accelerated. The four recommendations were: “a) Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses; b) Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation; c) Improve and expand the workforce providing evidence-based mental health services and supports; d) Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.”⁶²⁰

6) Technology is used to Access Mental Health Care and Information. The recommended strategies were: a) “Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations; b) Develop and implement integrated electronic health record and personal health information systems.”⁶²¹

For each of the recommendations, the Commission highlighted innovative model programs across the country where the strategy was being implemented. The highlights included a description of the program, goal, features, outcomes, biggest challenges, and ways that other organizations could adopt the lessons learned. Contact information for the model programs, including web site addresses, were published in the report.

While the mental health movement received a much needed boost in terms of direction, in Ohio, the Department of Mental Health, ever cognizant of its responsibilities as set forth in the Ohio Constitution, worked to further develop community based care while working to improve the efficiencies in the state operated hospitals. Re-engineering efforts were spearheaded in the areas of business functions, pharmacy, medical records, dietary and telecommunications to achieve the most efficient means of

⁶¹⁷ Ibid.

⁶¹⁸ Ibid.

⁶¹⁹ Ibid.

⁶²⁰ Ibid., p. 18.

⁶²¹ Ibid.

providing quality services. The result was that nearly \$800 million was saved that were passed onto the community in the initial ten years of the implementation of the Mental Health Act.

Clinical practices used a best practices approach whereby hospital functions were placed under system-wide product lines. In keeping with this development, the state hospitals have evolved into Behavioral Healthcare Organizations that were comprised of multiple state operated facilities. At the same time, Community Support Networks were developed whereby outpatient services could be provided by Department staff for distinct client populations consistent with the local community system of care.

All of these efforts helped the Department of Mental Health to achieve considerable savings while at the same time greatly improving the quality of services. The crowning achievement was the accreditation of all the behavioral healthcare organizations by the Joint Commission on Accreditation of Healthcare Organizations.

At both the federal and state levels the long and hard fight for mental health coverage parity with other health conditions finally brought about success. The 126th Ohio General Assembly enacted a state mental health parity law known as Amended Substitute Senate Bill 116. The Ohio Mental Health Parity law became effective on March 30, 2007. The tenets of the new law provided for mental health benefits for biologically based mental illness. The new law was applicable to most health benefit plans on October 1, 2007.⁶²² The key provisions of the new law were:

- 1) “Prohibits discrimination in the coverage provided for the diagnosis, care, and treatment of biologically based mental illnesses in sickness and accident insurance policies and in private and public employer self-insurance plans, with certain exceptions.”
- 2) “Includes biologically based mental illnesses as part of the definition of ‘basic health care services’ for purposes of the health insuring corporation law, thereby requiring all health insuring corporations that offer coverage for basic health care services to offer like coverage for these services, with certain exceptions.”
- 3) “Permits mental health services that must be provided by a licensed physician or psychologist in order to be included in certain health insurance coverage requirements to be provided by a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker.”⁶²³

The biologically based mental illnesses were defined in the law to include, “schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic

⁶²² Ohio Department of Insurance, ohioinsurance.gov

⁶²³ Am. Sub. S.B. 116, 126th Ohio General Assembly, Analysis, legislature.state.oh.us.

disorder.”⁶²⁴ The new law did not address other mental health disorders or substance abuse disorders. Nevertheless, Ohio could be proud of its achievement in bringing about greater parity of mental health coverage for its citizens.

At the federal level, twelve years had passed since the Mental Health Parity Act of 1996 opened the door to greater equality of benefits. On October 3, 2008, President George W. Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Although the key changes in the new law would not be effective until after October 3, 2009 the changes were a significant improvement over the initial Mental Health Parity Act of 1996. The key changes included the requirement that if a group health plan has both medical/surgical benefits and mental health benefits, “the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.”⁶²⁵ In addition, the treatment limitations cannot be more restrictive than those for medical/surgical benefits. The MHPAEA was a major step forward in achieving equality of mental health benefits, though the provisions of the MHPAEA only applied to group insurance and businesses with between two and fifty employees were exempted from the coverage requirement.⁶²⁶

National and state economic conditions continue to be a major factor in the present state and future development of the mental health system of care in Ohio. At the beginning of 2009, the Department of Mental Health was operating seven state hospitals. At the local level, fifty community mental health and alcohol, drug addiction, and mental health boards contracted with over four hundred fifty provider agencies serving more than a quarter million Ohioans.

The challenge facing the caring professionals presently in charge of mental health services in Ohio at the state or local level, be they policy maker, funder, advocate, or provider is to build upon the significant gains made over the past two hundred or so years of mental health treatment in the state. Just as our forbearers were not content with the status quo but rather continually sought ways to improve mental health services, constrained perhaps by available resources and knowledge but never limited by a lack of vision nor commitment, so may we follow in their path and continually seek to improve the lives of all Ohioans.

⁶²⁴ Ohio Department of Insurance, ohioinsurance.gov

⁶²⁵ “Mental Health Parity and Addiction Equity Act of 2008,” Center for Medicare and Medicaid Services, cms.hhs.gov.

⁶²⁶ H.R. 1424, Subtitle B, *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, U.S. Congress Record, p. 125.

Appendix B

Patients are Just People **By Robert J. Schmidt**

Robert J. Schmidt worked at the Columbus State Hospital as a psychiatric attendant during the 1950s and later as a social worker. Upon his retirement in 1984, he shared a copy of a story he wrote years before when he worked as an attendant. His unpublished short story provides a glimpse into life in the state hospital during the 1950s. Reprinted here are excerpts from his story, "Patients are Just People."

"Charlie, a gnome-like little guy on Ward 16,⁶²⁷ was barely five feet tall and if you put a brick in his pocket, the scale might say one hundred pounds. He hardly every spoke and when he did, The result was an incoherent jumble called, "Word Salad." He was usually alone and his favorite place was his room, where he would stand for hours staring out the window. He usually only left the room to eat, to bathe, and to shave. He ate his meals in the ward dining room.

"Inspection day was a day each week when we swept and mopped out patients' rooms, turned the mattresses and made up the beds with fresh bedding. When we did Charlie's room, we noticed a female robin sitting on his windowsill. She had a piece of string in her mouth and did not seem overly afraid of us. We laughed and went on to the next room.

"A week or so later, Charlie surprised us by taking a small sandwich with him as he left the dining room. When we asked him about it, his reply was an incoherent mess of words. We laughed, but let him get away with it. He continued to do this the next day and thereafter.

"We noticed a gradual improvement in Charlie. His speech was becoming more sensible – less word salad. His table manners improved. He would now ask people to pass things instead of reaching for distant items. We laughed and expected Charlie to gain weight, but when we weighed him, he hadn't gained a pound. This piqued attendant Ed's curiosity. He promised to watch Charlie.

"The next day, when Charlie started to return to his room, Ed quietly followed him and soon stood in the doorway to observe Charlie. Charlie, unaware of Ed's presence, broke the sandwich into small morsels, and laid them on the windowsill. Ed tiptoed closer and looked over Charlie's shoulder and gave a gasp of surprise at what he saw. The female robin was sitting on a nest. Charlie looked up startled, but relaxed when Ed smiled and gave him a reassuring pat on the shoulder. The robin showed no fear of Charlie, but watched Ed warily.

⁶²⁷ Ward 16 was the male maximum security unit for the Columbus State Hospital at the time.

“Charlie continued to take food to his room every day. He continued to improve. His walk now became a purposeful stride instead of the aimless slouching gait of an old patient...

“About a week or so later, Charlie took his usual sandwich from lunch, but this time, in passing, he invited Ed ... to visit his room. “Come and see,” he said with a twinkle in his eye. Ed followed him and, as he entered the room, he heard a clamor of raucous squalls. He saw that the eggs had hatched and that the mother was busily feeding and caring for her family. The little fellows didn’t have very many feathers, but their voices and their appetites were in great shape. Some time later, when the babies had grown feathers and were learning to fly, the mother taught them to eat bugs and worms instead of depending on Charlie’s sandwiches.

“It seemed a long drop from a second floor window to the ground. If the little birds couldn’t fly, either the fall would kill them or an ornery tom cat would have a meal. However, one after another of the babies took off and flew to the branch of a great oak tree...Charlie watched breathlessly as they tried and succeeded. Yes, his family had grown up and the children would go their separate ways. They would not return to the nest...

“Well, Charlie had the “blues” for a few days, and then he realized that he had grown up too. He would like to try his wings again.”⁶²⁸

⁶²⁸ Robert J. Schmidt, *Patients are Just People*, unpublished, June, 1984.

Appendix C

Board Association Survey Instrument

Appendix C

Board Association Survey Instrument

Purpose: ODMH is surveying the ADAMH / CMH Boards regarding the decision making processes when clients are referred and admitted for hospitalization from a Board policy and planning perspective. This survey is part of the Department's TSiG transformational federal grant, specifically related to access to adult inpatient care. The information will increase our understanding of the referral process and help identify opportunities to improve access and strengthen community care.

Board Name: _____ ID # _____

1. Does the Board have written policies, procedures or guidelines to follow for psychiatric hospitalization within your system of care?

Yes _____ No _____

2. Does the Board have written affiliations or agreements with local hospitals for adult psychiatric hospitalizations?

Yes _____ No _____ If yes, please list the hospitals:

- _____
- _____
- _____
- _____

3. Does the Board possess a Continuity of Care or other written agreement with its state operated hospital that addresses admissions, treatment, and discharge procedures, and management of confidential patient information?

Yes _____ No _____

4. Does the Board have a structure and process for managing adult inpatient utilization?

Yes _____ No _____

If yes, please describe briefly the process and structure.

5. Does the Board have a plan that outlines crisis intervention services? *[The Ohio Admin Code 5122-29-0 uses the term Crisis Intervention Services and defines it as: “(A) Crisis intervention is that process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic.”]*

Yes _____ No _____

List the Board’s crisis intervention services and indicate if the services are available 24/7/365.

Crisis Intervention Service	Is it Available 24/7/365? (Yes or No)

6. When the Board’s contract agencies determine that a client requires hospitalization, does the Board have policy provisions in place to utilize the client’s third party payer resources? Yes _____ No _____

Estimate the percentage of your private psychiatric hospital referrals that have third party coverage: _____%

7. Rate the frequency that you have experienced issues or concerns with the private or community hospitals regarding access to adult inpatient psychiatric care in the past year. If you are a multi-county Board, please relate your general experience across all the counties in your area. Select the number which best describes your experience.

1	2	3	4	5
Daily Access Issues	Frequent Weekly Access Issues	Occasional Monthly Access Issues	Infrequent Quarterly Access Issues	No Access Concerns

- a. If rated 1 through 4, briefly describe the access issues. Also, indicate if there are any substantive variations among the Board's counties to inpatient access.

- b. How far from your primary pre-screening agency is the closest private psychiatric inpatient provider?

- 0 to 5 miles _____
- 6 to 10 miles _____
- 11 to 20 miles _____
- 21 to 50 miles _____
- 51 to 100 miles _____
- Over 100 miles _____

- c. What are your primary impediments to accessing private adult inpatient psychiatric care? Check all that apply.

- Not enough beds _____
- Local hospitals will not serve _____
- Local hospitals cannot serve _____
- No local inpatient capacity _____
- No 3rd party insurance _____
- Client characteristics, co-morbidity issues _____

If an impediment, list frequent client characteristics / co-morbidity issues:

- _____
- _____
- _____
- Other _____

- d. About what percentage of your last twenty (20) referrals were accepted for admission by private psychiatric hospitals: _____%

- e. When the Board has local private access issues, what is the Board's system response?

- Refer to the state hospital _____
- Hold in local emergency services _____
- Look outside of local area for an available bed _____
- Other _____

8. Please rate your Board's access to State Hospital Beds. Select the number which best describes your experience.

1	2 Frequent	3 Occasional	4 Infrequent	5
Daily Access Issues	Weekly Access Issues	Monthly Access Issues	Quarterly Access Issues	No Access Concerns

a. If rated 1 through 4, briefly describe the state hospital access issues.

b. How far from your primary pre-screening agency is the closest state hospital?

- 0 to 5 miles _____
- 6 to 10 miles _____
- 11 to 20 miles _____
- 21 to 50 miles _____
- 51 to 100 miles _____
- Over 100 miles _____

c. What are your primary impediments to accessing local state hospital care?

- Not enough beds _____
- Medical clearance _____
- Diverting admissions to another state hospital or provider _____
- Client characteristics, co-morbidity issues _____

If an impediment, list frequent client characteristics / co-morbidity issues:

- _____
- _____
- _____
- Other _____

9. Please identify your top three suggestions to improve overall access to adult inpatient care and indicate whether your suggestions are directed to state hospitals, private psychiatric hospitals or both.

1. _____
2. _____

3. _____

10. Please comment on any issues pertinent to the topics in this survey

Thank you for taking the time to complete this survey.

Appendix D

Provider Council Survey Instrument

Appendix D

Provider Council Survey Instrument

Purpose: ODMH is surveying pre-screening mental health agencies / crisis care providers regarding the decision making processes when clients are clinically assessed as being in need of psychiatric hospitalization. This information will help us determine the elements that are considered in the pre-screening and referral process. This survey is part of the Department's TSiG transformational federal grant to better understand access to care issues at local and regional levels.

The clinical director or program director and the pre-screening/clinical staff who make decisions of where adult clients are referred for hospitalization should respond to survey questions.

Agency: _____ County (or Counties): _____

Title of Person Completing Survey: _____

1. During mental health crisis situations, when you assess the client's need for psychiatric hospitalization, what major factors are considered in determining the most suitable hospital provider? List factors by level of importance.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

2. Of the following client factors related to determining the most suitable hospital provider, please rank their relative importance from 1 to 6 with one (1) being the most important:

- ___ Appearance
- ___ Degree of violence
- ___ Number of prior hospitalizations
- ___ Third party payer coverage, including Medicaid and Medicare
- ___ Treatment difficulty
- ___ Other (specify): _____

3. Do you typically have more than one option in referring clients for adult inpatient care? ___ Yes ___ No

List your inpatient providers:

▪ _____	▪ _____
▪ _____	▪ _____

4. Are clients asked about their choice of hospitals?

___ Yes ___ No ___ Sometimes ___ Not Applicable*
*(because there are no choices in this community)

5. Are there written agency policies, procedures or protocols in place to guide the clinician's decision-making about where to hospitalize?

___ Yes ___ No Comments are welcome.

6. Is a client's Medicaid or other insurance coverage important in determining where you refer for hospitalization? Select the number which best describes what you do.

1	2	3
Very Important	Sometimes Important	Not Important

7. Are there specific agency policies, procedures, or protocols in place that require a client's Medicaid or other insurance coverage be determined during the pre-screening, intake or assessment process?

___ Yes ___ No Comments are welcome

8. When working with clients who have managed insurance plans (HMO, commercial, managed Medicaid, etc.) how often do you seek prior authorization before referring to a hospital provider? Select the number that best describes what you do.

1	2	3	4	5
Always	Very Often But Not Always	Often	Sometimes	Never

9. Does your agency have written agreements or affiliations with local private or state hospitals for adult psychiatric hospitalization?

Yes No If so, please identify which hospitals:

- _____
- _____
- _____
- _____
- _____

10. Please identify your top three suggestions to improve overall access to adult inpatient care and indicate whether your suggestions are directed to state hospitals, private psychiatric hospitals or both.

- 1 _____
- 2 _____
- 3 _____

Thank you for taking the time to complete this survey.

Appendix E
2010 Hospital Regions

Appendix E

2010 Hospital Regions' Profile

Appendix E is an updated snapshot of the hospital regions in 2010. The information is also an update to the Regional Viewpoints section at the conclusion of the 2004 *The Crisis in Ohio's Acute Mental Health Care* Report. One of the more obvious changes is the elimination of the term 'Collaborative' in referencing the hospital regions. Also, the regions are defined not by their state hospital name as in the 2004 report, but rather by their geographic location within the state. Since this is an updated report, the hospital closures are included since 2004; the 2004 Report having already delineated the hospital closures from 1997 to 2003. New with this updated report is a list of hospital openings as well. Each hospital is identified by name, county, and the respective number of adult, adolescent, and children beds. The source for the private hospital information is the ODMH, Office of Licensure and Certification and is current as of April 15, 2010. The state hospital data is from the ODMH Office of Hospital Services.⁶²⁹

Note: Geriatric specific beds are not in addition to adult beds. They are included in the total number of adult beds. Adolescent and children's beds are licensed separately. In some cases, hospitals can alternate the use of these beds between the two age groups. The 2007 Population estimate for each county and region is from the U.S. Census bureau.⁶³⁰

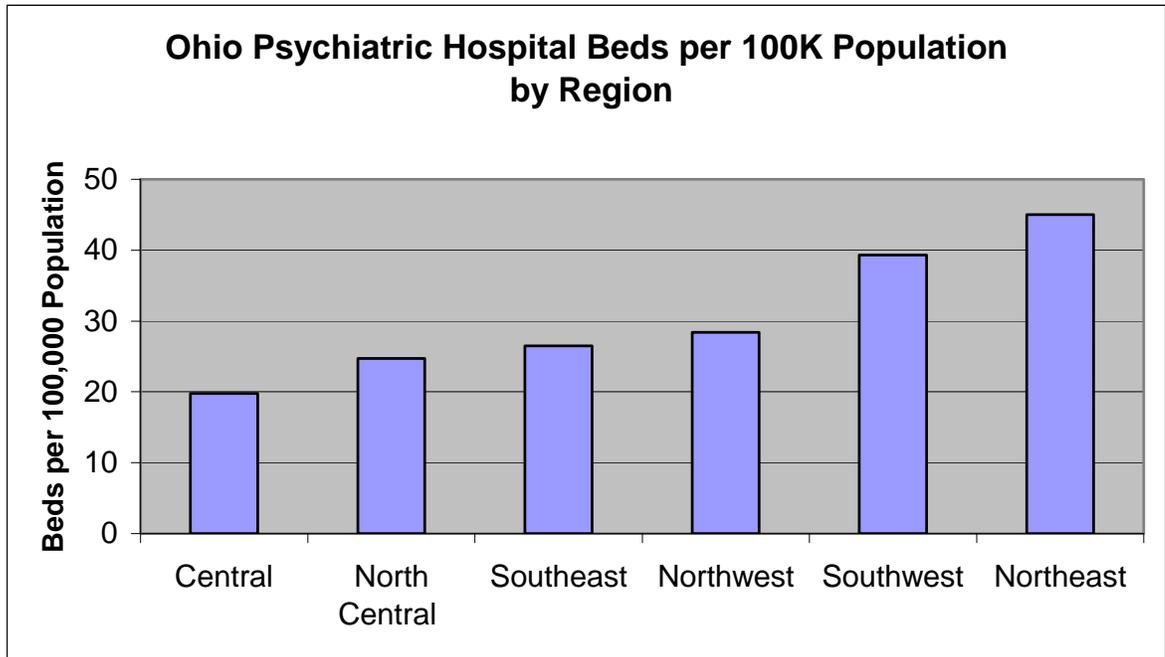
Using the 2007 Population estimates and the current number of beds in each region, we find that the beds per 100,000 population vary considerable across the state. The region with the fewest beds per 100,000 population is the Central Region at 19.8 beds. The region with the highest number of beds per 100,000 population is the Northeast region with 45.0 beds. See Figure No. 125 on the following page.

⁶²⁹ ODMH, Office of Licensure and Certification, Private Psychiatric Hospitals, 4/15/2009; ODMH, Office of Hospital Services.

⁶³⁰ U.S. Census Bureau, Population Division, *Annual Estimates of the Populations for the Counties of Ohio: April 1, 2000 to July 1, 2007*, Co-Est 2007-01-39. Release Date: March 20, 2008.

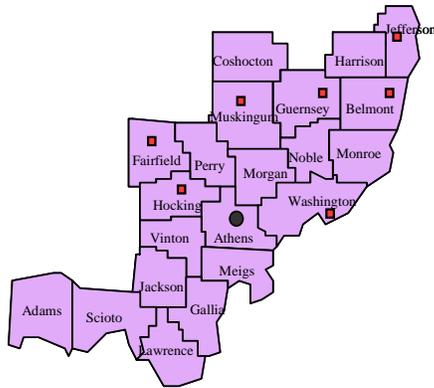
Figure No. 125.

Total Psychiatric Beds per 100,000 Population by Region



Source: ODMH, Offices of Licensure and Certification, and Hospital Services, as of 4/15/10
Based on 2007 Population Estimates by the U.S. Census Bureau

Figure No. 126.



Hospital Closures since 2004:

Belmont County: Fox Run
Guernsey County: Appalachian Behavioral Healthcare: Cambridge Campus
Washington County: Selby General

Hospital Openings since 2004:

Guernsey County: Cambridge Behavioral Hospital
Washington County: Selby General

Southeast Region

Counties: Adams, Athens, Belmont, Coshocton, Fairfield, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Morgan, Monroe, Muskingum, Noble, Perry, Scioto, Vinton, and Washington

Total Population (2007 Population [estimate]): 954,310

Total Psychiatric Beds per 100,000 Population: 26.5

State Hospital: **Athens Campus** – 88 Adult

Private Psychiatric Hospitals:

Belmont County: **Belmont Community** – 16 Adult

Fairfield County: **Fairfield Medical Center** – 6 Adult

Guernsey County: **Cambridge Behavioral** – 50 Adult

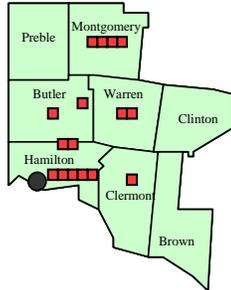
Hocking County: **Hocking Valley-** 10 Adult, 10 Geriatric Specific

Jefferson County: **Trinity East** – 20 Adult

Muskingum County: **Genesis Healthcare** – 30 Adult, 10 Adolescent, 4 Child

Washington County: **Marietta Memorial** – 19 Adult

Figure No. 127.



Hospital Closures since 2004:

Montgomery County:

Kettering Memorial
Twin Valley, Dayton Campus

Warren County: Middletown Regional

Hospital Openings since 2004:

Warren County:

Lindner Center
Atrium Medical (formerly Middleton Regional)

Southwest Region

Counties: Brown, Butler, Clermont, Clinton, Hamilton, Montgomery, Preble, and Warren

Total Population (2007 Population [estimate]): 2,265,007

Total Psychiatric Beds per 100,000 Population: 39.3

State Hospital: **Summit** – 284 Adult

Private Psychiatric Hospitals:

Butler County: **Fort Hamilton** – 20 Adult

Clermont County: **Mercy Clermont** – 30 Adult

Hamilton County:

Christ – 31 Adult, 10 Geriatric Specific
Cincinnati Children's (College Hill) - 30 Adolescent, 24 Child
Cincinnati Children's (Main Campus) – 15 Adolescent
Deaconess – 28 Adult, 28 Geriatric specific
Good Samaritan – 55 Adult
Mercy Franciscan (Mt. Airy) – 11 Adolescent, 11 Child
Mercy Franciscan (Western Hills) - 30 Adult, 30 Geriatric specific
University – 48 Adult

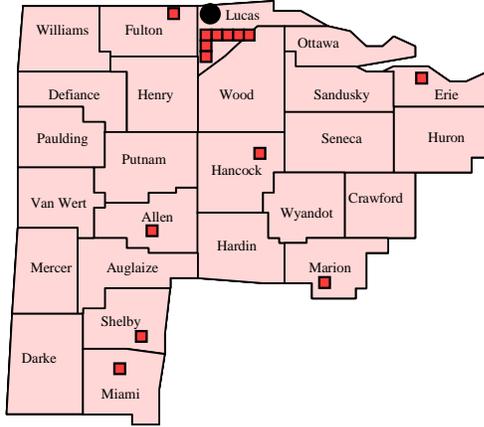
Montgomery County:

Good Samaritan – 29 Adult
Grandview – 60 Adult
Kettering Behavioral – 30 Adult, 15 Adolescent, 15 Child
Miami Valley – 35 Adult

Warren County:

Lindner Center of Hope – 32 Adult, 16 Adolescent
Atrium Medical – 42 Adult

Figure No. 128.



Northwest Region

Counties: Allen, Auglaize, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Lucas, Marion, Mercer, Miami, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood, and Wyandot

Total Population (2007 Population [estimate]): 1,882,635

Total Psychiatric Beds per 100,000 Population: 28.4

State Hospital: **Northwest Ohio Psychiatric Hospital** – 114 Adult

Private Psychiatric Hospitals:

Allen County: **St. Rita's** - 38 Adult (18 geriatric specific)

Defiance County: **Defiance Regional** – 10 Adult

Erie County: **Firelands Regional** – 26 Adult, 4 Adolescent

Fulton County: **Fulton County-** 10 Adult

Hancock County: **Blanchard Valley** – 9 Adult

Lucas County:

Flower – 55 Adult

Arrowhead – 24 Adult

University of Toledo – 8 Adolescent, 8 Child

Toledo Hospital – 19 Adult

Toledo Hospital: Children's – 18 Adult, 8 Adolescent, 2 Child

St. Charles Mercy – 65 Adult

St. Vincent Mercy – 31 Adult

Marion County: **Marion General** – 24 Adult

Miami County: **Upper Valley** – 21 Adult, 10 Adolescent, 8 Child

Shelby County: **Wilson Memorial** – 10 Adult, 10 Geriatric Specific

Van Wert County: **Lincolnway** – 12 Adolescent

Hospital Closures since 2004:

Lucas County: Focus Healthcare;

Toledo Children's

Sandusky County: Memorial

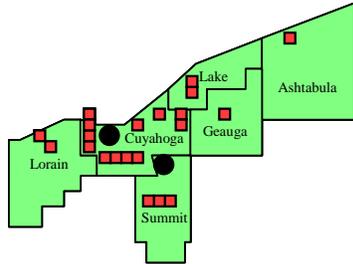
Hospital Openings since 2004:

Lucas County: Arrowhead

Toledo Children's

Van Wert County: Lincolnway

Figure No. 129.



Northeast Region

Counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, and Summit

Total Population (2007 Population [estimate]): 2,571,267

Total Psychiatric Beds per 100,000 Population: 45.0

State Hospitals: **Northcoast Cleveland** - 100 Adult
Northcoast Northfield - 180 Adult

Private Psychiatric Hospitals:

Ashtabula County: **Ashtabula County Medical** – 17 Adult

Cuyahoga County:

Cleveland Clinic: Euclid Hospital – 15 Adult
Fairview: 13 Child; **Huron Hospital** – 30 Adult
Lakewood – 32 Adult; **Lutheran** – 84 Adult
Marymount – 32 Adult, 8 Adolescent;
MetroHealth – 20 Adult; **Parma Community** – 14 Adult
South Pointe – 38 Adult; **Southwest General** – 36 Adult, 4 Adolescent
St. Vincent’s Charity – 96 Adult; **University Hospitals** – 42 Adult, 20 Geriatric specific
University Hospitals (Rainbow Babies & Children’s) - 9 Adolescent, 5 Child

Gauga County: **UH Geauga** – 20 Adult

Lake County:

Lake Health – 18 Adult, 18 Geriatric specific;
Windsor-Laurelwood – 78 Adult, 38 Adolescent, 12 Child

Lorain County:

Community Health – 19 Adult, 5 Adolescent; **EMH Regional** – 12 Adult

Summit County:

Akron General – 55 Adult; **Summa Barberton** – 30 Adult
Akron Children’s – 14 Adolescent, 10 Child; **St. Thomas** – 71 Adult

Hospital Closures since 2004:

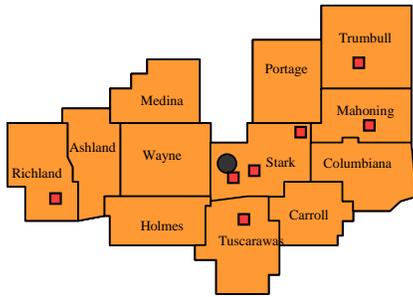
Cuyahoga County:

- Deaconess
- St. Michael
- Windsor
- Meridia Euclid
- Barberton Citizens

Hospital Openings since 2004:

- Fairview
- Summa Barberton

Figure No. 130.



Hospital Closures since 2004:

Columbiana County: East Liverpool City

Mahoning County: Forum Health

Richland County: Samaritan Regional

Stark County: Doctor's

Hospital Openings since 2004:

Tuscarawas County: Ten Lakes

North Central Region

Counties: Ashland, Carroll, Columbiana, Holmes, Mahoning, Medina, Portage, Richland, Stark, Tuscarawas, Trumbull, Wayne

Total Population (2007 Population [estimate]): 1,566,507

Total Psychiatric Beds per 100,000 Population: 24.7

State Hospital: **Heartland** - 130 Adult

Private Psychiatric Hospitals:

Mahoning County: **St. Elizabeth's** – 20 Adult

Richland County: **MedCentral Health** – 32 Adult, 9 Adolescent

Stark County:

Affinity Medical – 15 Adult

(formerly Massillon Community)

Alliance Community – 12 Adult, 12 Geriatric Specific

Aultman Health – 41 Adult

Mercy Medical – 30 Adult

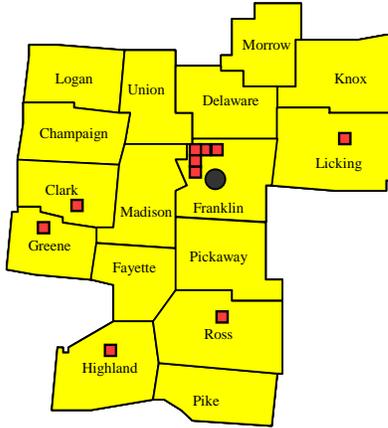
Tuscarawas County: **Ten Lakes** – 16 Adult

Trumbull County:

Belmont Pines – 34 Adolescent, 12 Child

Trumbull Memorial – 36 Adult

Figure No. 131.



Hospital Closures since 2004:

Franklin County: Doctors West
Union County: Memorial Hospital

Hospital Openings since 2004:

Pomegranate Health Systems

Central Region

Counties: Champaign, Clark, Delaware, Fayette, Franklin, Greene, Highland, Knox, Licking, Logan, Madison, Morrow, Pickaway, Pike, Ross, and Union

Total Population (2007 Population [estimate]): 2,227,191

Total Psychiatric Beds per 100,000 Population: 19.8

State Hospital: **Twin Valley**- 164 Adult

Private Psychiatric Hospitals:

Clark County: **Mental Health Service** – 16 Adult

Franklin County:

Mt. Carmel West – 20 Adult

Ohio State University Hospitals – 58 Adult, 20 Adolescent, 16 Child

Ohio Hospital of Psychiatry – 26 Adult, 14 Adolescent, 10 Child

Pomegranate Health Systems – 10 Adolescent

Riverside Methodist – 39 Adult

Greene County: **Greene Memorial** – 19 Adult, 19 Geriatric Specific

Highland County: **Highland District** – 10 Adult, 10 Geriatric Specific

Licking County: **Licking Memorial** – 9 Adult

Ross County: **Adena Regional** – 10 Adult

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