Ohio's Disability Service Systems: Historic Overview of the System, Current Perspectives, and Proposed Changes

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Disability Rights OHIO

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Presentation Overview

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Presentation Objectives

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1. Gain basic understand of the complex history of Ohio's approach to providing "services and supports" to people with disabilities;

2. Learn why Ohio decided to establish the county board systems that provide services and supports to individuals;

3. Gain a basic understanding of the overall movement for deinstitutionalization and the three major components of that shift: 1) hospitals were cruel and inhumane; 2) new treatments allowed for stabilization outside of the hospitals; and 3) the desire to reduce state expenditures on the care of individuals labeled with mental illness, developmental disabilities, and intellectual disabilities;

4. Understand the complex reasons as to why Ohio's mental health system has never reached the potential laid out in the Mental Health Act of 1988;

5. Learn about the ongoing efforts to reform the system and initiate changes that could have negative impacts on the lives of individuals.

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TRIGGER WARNING

Part One – Historic Approach to Disability

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Section 1 - Pre-institutionalization

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- 1247: Bedlam
  - First Psychiatric Hospital
- 1600s-1700s: Early America
  - Poor Houses
  - Homelessness
  - Jails

Section 2 - Institutionalization

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- 1700s: Quakers
  - Humane Treatment
- 1752: Pennsylvania Hospital
  - Dr. Benjamin Rush – father of psychiatry
  - Saw disability and "madness" as treatable and began experimenting with inhumane treatments
- 1850s: Dorthea Dix
  - Humane treatment and the construction of state psychiatric hospitals
- Early 1900s: Eugenics and Diagnostics
  - Freud, Kraepelin, and Goddard
  - Medical Model and the "biology" of disability
  - These theories gave way to inhumane treatment

Section 3 – Pre-Deinstitutionalization

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- 1908: Early Mad Pride & Psychiatric Survivors Movement
  - Clifford Beers – Mental Health America
  - Outpatient Treatment
- 1900s-1920s: "Advances" in Medicine & Treatment
  - Eli Lilly began mass producing insulin
  - Psychiatry saw this as an opportunity to treat the "insane" and "feeble-minded"
  - Expansion of inhumane treatments
- 1930s: Great Depression
  - States faced budget cuts leading to warehousing of individuals in large institutions
- 1946: National Mental Health Act
  - Life Magazine
  - NIMH
- 1948: The Snake Pit and WWII

Section 4 – Deinstitutionalization

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- 1950s: NIMH Reports
  - The role of federal government
  - Community-based care
- 1961: Action for Mental Health
  - Report detailing the need for humane treatment
- 1963: Community Mental Health Centers Act
  - Goal of 2,500 by 1991 there were 1000
- 1970s: Medicaid and Medicare
  - In 1972 amendments were made to the program to support individuals living independently in their community
- 1980s: Failed Promise & Budget Cuts
  - Reagan administration began making cuts to systems that supported people with disabilities and shifted funding into block grants

Section 4 – Deinstitutionalization

(Protection & Advocacy Legislation & Supreme Court Cases)

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- 1973: Section 504 of the Rehabilitation Act
- 1975: Individuals with Disabilities Education Act
- 1975 & 1986: Protection & Advocacy System
- 1990: Americans with Disabilities Act
- 1975: O'Connor v Donaldson
- 1999: L.C. v Olmstead

Section 4 –Pre-Reinstitutionalization

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- 1990s: Jails and Prisons
  - Growing populations of individuals with mental health labels
- 2000s: Great Recession
  - Decreasing state budgets for disability service systems
- 2010s: Involuntary Treatment
  - System capacity issues; advocacy groups seek new approach to mental health including expanding the use of court ordered treatment
- 2020: State Psych Hospitals and the IMD Restriction
  - Advocacy groups looking to remove these restrictions and expand state psych hospital capacity

Part Two – Ohio's Disability Service Systems History

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Section 1: Pre-Institutionalization

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- 1803: Ohio's Admission into the Union
  - Poor Houses
  - Jails
  - Homeless

- 1815: Ohio's First Hospitals
  - Commercial Hospital and Lunatic Asylum for the State of Ohio in Cincinnati
  - State appropriated funds for the construction but administered by the county

Section 2: Institutionalization

- 1837: Ohio Lunatic Asylum
  - Provide care to those who were "curable"

- 1815: The Ohio Constitution
  - *"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."*

Section 2: Institutionalization Cont.

- 1855-1898: Construction
  - Cleveland, Dayton, Athens, Toledo, Massillon
  - The State created separate institutions for the care of the "feeble-minded" and the "insane;" Ohio titled these as training institutions and state hospitals respectively

- 1911: The Ohio Department of Public Welfare
  - Trustees were the original governing structure
  - In 1921 The Department of Public Welfare took over control of the state institutions
  - Initial Department Report

- 1915: Dangerous Patients
  - The state transferred patients into one hospital that were deemed dangerous
  - Lima State Hospital

- 1940s: Expansion of the System
  - Capacity issues in the 1930s; The Department continued to express concern over state funding for the care of individuals
  - Receiving units in Apple Creek, Youngstown, Cuyahoga Falls, and Cleveland

- 1954: The Department of Mental Hygiene and Correction
  - The Department of Public Welfare became the largest and most complex state agency
  - The General Assembly decided to break apart the Department and separate the care of people with disabilities into a new agency

Section 3: Pre-deinstitutionalization

- 1960s: Caring for Youth & the Horn Report
  - State began constructing institutions specifically designated to care for children
  - Gov. DiSalle commissioned a report which found the state should develop a county-based system for people with disabilities and separate the care of mental health and intellectual and developmental disabilities

- 1967: Community Mental Health Boards and County Boards of Mental Retardation
  - SB 648 and SB 169
  - Hospital capacity
    - Resident population: 1960: 28,500; 1967: 21,300; 1970: 10,000
  - This new system allowed individuals the opportunity to enter employment

- 1972: Department of Mental Health and Retardation
  - The State established a new separate department specifically to providing services to people with disabilities

- 1975: Ohio Legal Rights Service
  - SB 336 – aimed at providing legal representation to individuals in Ohio's Developmental Centers
  - By 1980 OLRS was designated as the P&A and in 1986 services were expanded with the PAIMI grant

- 1980: Department of Mental Health & Department of Mental Retardation and Developmental Disabilities
  - HB 694 established the Citizen Advocacy Boards which were comprised of consumers and family members to provide recommendations and oversight of each state institution

Section 4: Deinstitutionalization

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- The Mental Health Act of 1988
  - Before Introduction
    - New research
    - Common Concerns Group
    - Hospital capacity: 4,000 (admissions and discharges same as 1960)
    - SB 156
  - Principles of the Act
    - Focus on people
    - Consumer-centered
    - Empower individuals
    - Racially and culturally appropriate
    - Flexible
    - Focus on strengths
    - Normalized and incorporate natural supports
    - Meet special needs
    - Accountable
    - Coordinated
    - Integrated
    - Public/private partnership

Section 4: Deinstitutionalization Cont.

- 1991: Mental Health Act Implementation Report
  - State hospital population was reducing significantly but the state funding was not being shifted into the community
  - State budgetary decreases are stressing the system capacity
  - Provider access and capacity building has not met the goal of the legislation
  - Need to reevaluate the role of state psych hospitals
  - Great need to elevate the consumer voice

Section 5: Pre-Reinstitutionalization

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- 2013: Ohio Department of Mental Health and Addiction Services
  - Department of Alcohol and Drug Addiction was folded under the Department of Mental Health
  - Reduce redundancy and focus the states resources on substance use
  - As the opioid epidemic took hold of Ohio the state department continued to shift its focus away from mental health
- 2014: Assisted Outpatient Treatment Statute
  - SB 43 established a new criteria in the civil commitment statutes to allow courts to provide community-based “treatment” – only about 20 counties have adopted AOT
- 2018: Behavioral Health Redesign
  - Services for behavioral health shifted from fee for services to Medicaid Managed care which has stressed the system and cause budget shortfalls for community providers

Part Three – Legislative Overview

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Section 1: Overview of the General Assembly

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- 99 members of the Ohio House
  - 61 Republicans (65); 38 Democrats (34)
- 33 members of the Ohio Senate
  - 24 Republicans; 9 Democrats
- Speaker Bob Cupp; President Matt Huffman
- GA increasingly conservative
- Resentment for Gov. DeWine

Section 2: Budget Advocacy Goals

- Increase in funding to home and community-based services and supports
- Ohio HCBS Coalition
  - Nursing Facilities are a dangerous setting during the pandemic
  - DRO formed a coalition with over 50 partners to advocate for increased investments into the HCBS service systems
  - Coalition now consists of over 80 organizations and 20 individuals
- Current proposed amendment would increase ODM and ODA hcbs provider rates by 5% each year of the biennium
- OMHAS providing $11M over the biennium for “multi-system adults” to decrease utilization of psychiatric hospitals, jails, nursing homes, and homelessness
- ODE’s student success and wellness funding will be increased to $1B over the biennium for schools to use for mental health services

Section 3: DRO Advocacy Goals for the 134th GA

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- Post budget: advocate for a quality mental health system that bolsters provider capacity, is person-centered, relies on community-based supports, and free from force

- HB 162 – Disability Terms
  - Creates the ABLE Committee to review derogatory language within the ORC

- SB 2 – Competency Restoration
  - Goal to reduce capacity within state psychiatric hospitals
  - Need to expand system capacity

Section 4:
Questions to Consider

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- Causes of institutionalization
- Drivers of deinstitutionalization
- Current forces of reform
- View of deinstitutionalization as a failure
- The movement towards deinstitutionalization
  - Moral; ethical; or cost saving
- The consumer voice
- Stigma and ableism in the system
- Causes of system failure
- Protection of rights
- Building a robust system

Questions?

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