

Allowing Licensed Professional Clinical Counselors to Initiate the Ohio Mental Health Hold

(i.e., to Sign the *Application for Emergency Admission to a Hospital*
In Accordance with Sections 5122.01 and 5122.10 ORC)

A Fact Sheet

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Mental health professionals, including clinical counselors have a statutory “duty to protect” third parties from harm threatened by one of their clients

As a licensed mental health professional in the State of Ohio, a Licensed Professional Clinical Counselor (LPCC) who has reason to believe that a person with mental illness, if allowed to remain at liberty pending examination, represents a substantial risk of physical harm to self or others, the LPCC has a statutory duty to protect third parties from harm. As described in ORC §2305.51, the LPCC’s duty to protect is triggered whenever “a client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat.” An LPCC also has a professional duty to attempt to protect clients from harming themselves.

When a mental health professional’s “duty to protect” is triggered, the mental health professional must take one of four actions

When a mental health professional’s “duty to protect” is triggered, the mental health professional must take at least one of the following four prescribed actions:

- (1) Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;
- (2) Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122. of the Revised Code;
- (3) Establish and undertake a documented treatment plan that is reasonably calculated...to eliminate the possibility that the client or patient will carry out the threat, and, ... initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan...;
- (4) Communicate to a law enforcement agency...and if feasible, communicate to each potential victim or a potential victim's parent or guardian...(a) the nature of the threat; (b) the identity of the mental health client or patient making the threat; [and] (c) the identity of each potential victim of the threat.¹

Unfortunately, under current law, a licensed professional clinical counselor is not authorized to sign the statement of belief on an *Application for Emergency Admission* to a hospital (the state mental

¹ ORC § 2305.51. Immunity of mental health professional or organization as to violent behavior by client or patient

health hold) which is required to initiate options (1) or (2). It is this ORC §5122.10 authority that licensed professional clinical counselors are seeking.

ORC §5122.10 authorizes certain mental health professionals and law enforcement officers to detain and transport certain persons who pose a threat of serious harm to self or others to a hospital for evaluation and possible admission.

ORC §5122.10 states: *Any psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff may take a person into custody*, or the chief of the adult parole authority or a parole or probation officer with the approval of the chief of the authority may take a parolee, an offender under a community control sanction or a post-release control sanction, or an offender under transitional control into custody and may immediately transport the parolee, offender on community control or post-release control, or offender under transitional control to a hospital or, notwithstanding [section 5119.20](#) of the Revised Code, to a general hospital not licensed by the department of mental health where the parolee, offender on community control or post-release control, or offender under transitional control may be held for the period prescribed in this section, *if the psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff has reason to believe that the person is a mentally ill person subject to hospitalization by court order under division (B) of [section 5122.01](#) of the Revised Code, and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.*

Granting clinical counselors the power to sign the *Application for Emergency Admission* to a hospital will increase public safety by allowing them to more effectively discharge their “duty to protect”

As noted earlier, when an LPCC’s duty to protect is triggered, the duty may be discharged by taking at least one of four statutorily prescribed actions. The first two of these prescribed actions involve exercising ORC 5122.10 statutory authority to sign the *Application for Emergency Admission* or “state mental hold” form which allows a police officer to detain and transport the client to a hospital where the client may be evaluated for emergency voluntary or involuntary admission. This authority is not currently granted to LPCCs.

Without statutory authority to sign the *Application for Emergency Admission*, critical time is lost, especially for LPCCs in private practice, while the LPCC arranges for the client to be re-evaluated by another mental health professional who has the authority. Further, the risk to public safety is increased, since until the order to detain and transport the person to a hospital is signed, the client may not be detained against their will even if the client’s symptoms escalate.

Ohio clinical counselors are qualified by training, experience, and license to have this authority

All Ohio LPCCs are rigorously trained. All LPCCs must complete a two-year graduate program in counseling. Board specifications for course work include a supervised, 600 clock-hour internship in which the intern gains supervised practice in assessment, diagnosis, and treatment of mental and emotional disorders. On completion of the master’s degree, all seekers of the LPCC must pass a Board approved examination which assesses general knowledge and skill, complete 3000 clock hours of supervised clinical work experience, and then pass a second Board approved

examination covering knowledge and skill in clinical mental health counseling. Only after completing this rigorous training and evaluation can an applicant be licensed as an LPCC.

In fact, clinical counselors across the country are qualified by training, experience, and license to assess, diagnose, and treat mental and emotional disorders.

A review of state statutes reveals that the practice of counseling is regulated by statute in 49 of the 50 states and the District of Columbia (50/51 = 98%). In all states, counselors are permitted by license to treat mental and emotional disorders. In 47 (47/51 = 92%) of the states, clinical counselors are permitted to independently assess and diagnose mental and emotional disorders. At least six states permit independently licensed clinical counselors to sign their state's version of a state mental hold when a mentally ill client presents grave risk of harming self or others.

Evidence shows that granting clinical counselors the authority to sign the *Application for Emergency Admission* would not result in a dramatic increase in involuntary commitments or overload hospitals with patients awaiting evaluation

Previous opponent testimony has argued that were LPCCs to be added to the list of mental health professionals who may sign the *Application for Emergency Admission* to a hospital, it might reduce protection against curtailment of client rights and that therefore hospitals could be overwhelmed by an unchecked increase in the number of individuals detained and transported there for evaluation. Research evidence debunks this assertion.

In *Estates of Morgan v. Fairfield Family Counseling Ctr.* (1997), the Ohio Supreme Court observed that while it is reasonable to be concerned that if a duty to protect third parties against harm threatened by mentally ill clients was imposed, “therapists [might] attempt to protect themselves from liability by involuntarily hospitalizing nonviolent mental patients,”² To determine the reasonableness of this fear, the Court, citing a 1984 study by Givelber, Bowers and Blicht, concluded: “the statistical evidence that is available indicates that Tarasoff has not discouraged therapists from treating dangerous patients, nor has it led to an increased use of involuntary commitment of patients perceived as dangerous.”³ While this court finding does not directly address the issue of whether empowering LPCCs to sign the statement of belief on the *Application for Emergency Admission* to a hospital, it affirms the use of empirical evidence in resolving questions of probable consequence.

Evidence from the State of Florida (one of six states which permit independently licensed clinical mental health counselors to sign their state mental hold authorization form speaks directly to the issue. In Florida, Licensed Mental Health Counselors (LMHCs) are authorized under Florida's Baker Act to initiate involuntary examinations. Under the Baker Act, listed Florida mental health professionals “may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based” [2004 Florida Statutes, Title XXIX, §394.463(2)(a)3], authority similar to that granted to certain mental health professionals under ORC §5122.10.

² *Estates of Morgan v. Fairfield Family Counseling Ctr.* (1997), p. 25.

³ *Estates of Morgan v. Fairfield Family Counseling Ctr.* (1997), p. 26.

To determine the fiscal impact of granting this authority to LMHCs, the State of Florida's Baker Act Workgroup commissioned a study⁴ which was conducted by a Florida mental health institute. Data on the incidence of use of Baker Act authority following admission of LMHCs to the list of authorized mental health professionals was compared to Baker Act data collected in the year prior to LMHC authorization. The results of this study were overwhelmingly clear:

- “There was no fiscal impact as a result of adding LMHCs as a mental health professional authorized to initiate examinations. This finding is based on the negligible change in the total number of examinations, the number of examinations by mental health professionals, and the relative percentages of exams by mental health professionals, law enforcement officials, and judges.”

From the findings of the Florida study, it is reasonable to believe that if Ohio LPCCs were to be added to the list of mental health professionals with ORC §5122.10 authority, public safety would be increased without appreciable increase in the burden placed on hospitals.

The Health Officer System provides limited access to ORC §5122.10 authority.

Opponent testimony has suggested that clinical counselors who believe they need ORC §5122.10 authority should simply apply to a local Behavioral Health Board for designation as a Health Officer. It is because the health officer system was not designed to empower independently licensed mental health professionals that the initiative to empower clinical counselors to sign the *Application for Emergency Admission* to a hospital was launched. To document how Behavioral Health Boards administer Health Officer designations, OMHCA conducted a study.

In our study, a random sample of 15 Behavioral Health Boards across the State of Ohio (26% of the 57 boards representing 39% of the State's 88 counties) was contacted by telephone and asked a set of standard questions. The findings were clear: Across the state, Health Officer designation is granted almost exclusively to mental health professionals who work for a Board-designated, public sector contract agency—only one behavioral health board granted Health Officer designation to private practice mental health professionals. While some Behavioral Health Boards delegated responsibility for selecting Health Officers for their contract agency, most (87%) required their contract agency to nominate candidates who were then reviewed and approved by the Board. This level of oversight and control is necessary because in more than half the counties, Health Officer designation is granted to mental health professionals who have not earned a license for independent practice of their profession.

The results of this survey are clear: Behavioral Health Boards confer the title of Health Officer almost exclusively to individuals who work for specific, board designated contract agencies. Strong local oversight is necessary because Behavioral Health Boards may grant the authority of a Health Officer to individuals who are not independently licensed mental health professionals. In most counties, very few LPCCs can qualify for designation as a Health Officer, not because they are unfit to use this authority skillfully and ethically, but because they are not employed in a Board designated contract agency. LPCCs in private practice or in an agency which is not a Board designated contract agency by Board policy are not considered.

⁴ Baker Act Workgroup (2005, March 1). The fiscal impact of permitting licensed mental health counselors to initiate Baker Act involuntary examinations. Retrieved 11/28/2006 from <http://www.fmhca.org/bawrkgrp.pdf>.

This initiative is widely supported

This bill is endorsed in Ohio by the Ohio Counseling Association and the Ohio Mental Health Counselors Association. Nationally, it is endorsed by the American Counseling Association, the American Mental Health Counselors Association, and the National Board for Certified Counselors.

Granting clinical counselors the power to sign the *Application for Emergency Admission* to a hospital does not confer admitting privileges

Granting LPCCs the authority to sign the statement of belief on an application for emergency admission to a hospital (the state mental health hold form) would not give counselors the power to hospitalize anyone. SB-53 only allows the enumerated mental health professionals and law enforcement personnel to authorize detention and transportation of a mentally ill person who represents a substantial risk of physical harm to self or others to a hospital for observation. Once the person gets to the hospital, the detainee is turned over to a person with the authority to hospitalize who can then observe, evaluate, and make the admissions decisions.