Historical Trends Applying to Michigan re Incarceration of Mental Illness

Presentation by Mark Reinstein, Mental Health Assn. in Mich., Dec. 14, 2012
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Let me begin with what we're looking at here regarding use of justice systems to deal with mental illness.

In the late 1990s, the Department of Community Health utilized Wayne State University to do diagnostic clinical interviews with a random sample of county jail inmates from Wayne, Kent and Clinton. Looking at primary diagnosis, and excluding substance abuse as a mental illness, the investigators found a 51% rate of any mental illness, and a 34% rate for one of the following: bipolar disorder; major depression; schizophrenia or other psychotic disorders.

In 2010, U-M released a study of diagnostic clinical interviews with a random sample of state prison inmates. Over 20% displayed symptoms of severe mental disability. There was no overall report on the prevalence of any mental illness, but based on reporting for a few of the sub-scales used, it appears that the percentage would have been considerably higher if investigators weren't looking for just severity.

I'm unaware of any independent study on mental illness/emotional disturbance in Michigan's juvenile justice system. National studies often report seriousness between 50-75%, depending on how one classifies conduct disorders. Thank to Partners in Crisis, there is a 2013 appropriation and legislative requirement for independent study of the situation within the juvenile justice system. Work is already underway on that.

One of the key factors involved with incarceration is what we do/don't have available in terms of state-operated psychiatric hospital beds, the only resource generally available for non-acute (non-short-term) intensive, protected treatment of severe mental illness. Do I think the vast majority of persons with mental illness need or will ever require psychiatric hospital care? No. But do we have enough non-acute beds to meet the clinical needs that exist? No.

In the mid-1980s, we had 16-17 state-operated psychiatric hospitals (depending on whether or not one counts the Forensic Center), with about 3,500 available beds. From 1987-2003, we closed 12 of these facilities, with 10 of the closures occurring in the 1990s.

Today we have 4-5 state-operated psychiatric hospitals (depending on if one counts the Forensic Center). We are budgeted in FY-13 for 893 beds including the Forensic Center, and 683 beds without it. And it can conservatively be estimated that at least two-thirds of those 683 non-Forensic Center beds are presently filled by forensic cases – i.e., those incompetent to stand trial or not guilty by reason of insanity.

We've had about an 80% bed decrease capacity since the mid-80s, and we're left with one of the lowest rates of state psychiatric hospital beds in the country – about 9 per 100,000 if counting the Forensic Center, and about 7 per 100,000 minus that facility.

In late 1997, when the closures of the '90s were complete or near so, The Detroit News reported that the number of state prison inmates with previous state psychiatric hospital stays had gone up by 500 from 1993-97 (from 2,200 to 2,700), an increase of almost 25%. The following year, the Senate Fiscal Agency (SFA) subjected those figures to statistical testing, controlling for the growth in total prison population that was otherwise occurring. The SFA determined that the increase of inmates with previous state hospital stays was statistically significant at the 95% confidence level.

In the 2010 U-M study, inmates receiving mental health services were asked if they had ever experienced a psychiatric hospitalization of any type. Fort-one percent of respondents said they had. This was a self-report item, and it wasn't limited to state-operated psychiatric beds. Nonetheless, it is an alarming figure.

In 2000, nine Michigan mental health and human service groups recommended that the state's number of non-acute psychiatric hospital beds (which then stood at 1,173 with the Forensic Center, and 963 without) be increased by at least 400, strategically disbursed around the state. Those so recommending suggested the new beds could be directly state-operated or could be contracted by the state (as long as contracted entities were required to provide care longer than acute-only).

Another huge factor in where we are today is economics. Money is not always the answer to everything, but it is typically a huge elephant in the room.

Our public mental health system is not adequately or comprehensively funded, as I'll highlight in the following three focal points:

*The vast majority of the base money (89%) appropriated to Community Mental Health (CMH) for care, treatment and support in FY-13 is reserved for Medicaid enrollees. The situation has been like this for over 10 years, even though many with mental illness who approach or could benefit from CMHs are not eligible for – or cannot maintain continuous enrollment in – Medicaid.

*Partially (but not totally) related to the above point, CMHs on a statewide average basis do not spend enough on mental illness clients. For FY-10, the average annual statewide expenditure for an adult with mental illness was under $5,200; for a youth with mental illness, $3,850; and for someone with a developmental disability, over $26,200. This has been a long-standing historical trend. I'm not suggesting spending for persons with developmental disability should be decreased, nor am I calling for per-client expenditures among all three of these groups to be the same. But I am advancing that what we spend on adults and children with mental illness is not enough to get the job done.

*And while CMH appropriations are more than they used to be, there are mitigating factors involved. In 2004, Governor Granholm's Mental Health Commission devoted an entire appendix section to some of the funding problems that had taken place. The Commission concluded that CMH General Fund appropriations were decreasing from a practical standpoint, and Medicaid mental health funding had not been leveraged as effectively as possible. Here are some excerpts: "In its 2003 report…the SFA explains that…much of the increase in CMH expenditures over the years has not been an actual funding increase, but rather has been a shift in funding from state-run programs to locally run programs…Average base funding increases to Michigan mental health general fund expenditures in the past 20 years have been less than the base reductions: the average annual increase of 1.0 percent has been more than offset by the average annual base reduction of 1.2 percent. In comparison, the state's total general fund spending rose 83 percent in the same period. General fund appropriations to mental health are…$57 million less than they would be if Consumer Price Index (CPI) increases were granted for fiscal years 1999-2005…Limited economic increases have even hit Medicaid mental health services. As the SFA report notes, 'the rate of growth since 1998-99 has been far lower than the previous growth'…Medicaid funding of $1.4 billion is $235 million less than it would be if CPI increases had been appropriated starting in FY-1999."

Some may deem the CMH Medicaid funding situation has improved since 2004, but even if you're of that opinion, we previously left too much on the table that could have been procured. And the non-Medicaid situation is dire, and may become even more so if Michigan opts to expand Medicaid under the Affordable Care Act and state lawmakers subsequently decide they can spend even less on CMH non-Medicaid than they do today. The Mental Health Commission recommended an annual, dedicated state fund for Mental Health of $500,000 from closure of certain tax loopholes and applications of certain use funds. That recommendation is sitting on a shelf.

My last topic area today is Assisted Outpatient Treatment (AOT) and other civil commitment issues. AOT is one potentially helpful tool that exists, and civil commitment (court-ordered treatment) is one category of tools. Actions here, by themselves, won't solve everything, but they can be part of a broad-based set of effective approaches from various domains.

AOT, which allows court-ordered treatment for individuals who are noncompliant with treatment recommendations and have certain characteristics in their recent history, has existed in Michigan since 2005. To the best of my knowledge, only Oakland County has made consistent use of it. Someone from Oakland just told me the county is processing 50-60 cases a year. In a 2009 report from the Departments of Corrections and Community Health, it was stated that Oakland had processed 300 cases in the law's first three years.

I have heard many positive things about AOT from Oakland officials, but I'm not aware that the county has put out a formal report on its use and outcomes. A draft work group report on justice system diversion for adult mental illnesses went to the Governor this summer, and it recommended a statewide survey of courts and CMHs regarding attitudes

about and knowledge/use of AOT. The draft also recommended focused interviews with Oakland County officials to benefit from their AOT experiences. If the Governor accepts these recommendations, we'll be better positioned to decide how to proceed on this issue in Michigan.

AOT is a potentially helpful conceptual tool. Whether and what revisions we should make to it are legitimate policy questions, and the law's potential would certainly be enhanced if money was attached to it (as was the case in New York). It is just one tool, however, under civil commitment. Aside from AOT, which can only be applied to certain cases, there are three other criteria for court-ordered treatment in Michigan:

*An imminent danger to self or others, as evidenced by recent actions.

*Grave disability stemming from demonstrated inability to tend to essential self-care tasks.

*Inability to understand need for treatment, coupled with competent clinical opinion that such lack of recognition can reasonably be expected to contribute to behavior dangerous to self or others.

The last of these three criteria can only be initiated by a court petition; the other two can be initiated by certain health professionals prior to an ultimate court hearing.

There is considerable debate in Michigan about whether we should be able to order into treatment, irrespective of previous history, someone who is deemed likely to present a future danger to self or others (but is not deemed an imminent threat); and, if so, whether the last of the three traditional criteria is sufficient to do that. Even if it is, my observation from 30 years experience in mental health in Michigan is that the key players involved in civil commitment – courts, CMHs and other mental health providers – have settled into a general statewide picture where the imminent-danger criterion is the predominant tool used, at the expense of the other tools, when it comes to civil commitment decisions. (Under our laws, any of the three criteria can apply for a civil commitment, and AOT for cases meeting its particulars can apply by itself.)

Civil commitment issues are complex and require balancing of civil liberties with the health and safety of individuals and society. Unless we can find better balance than we have now, it will be hard to make a serious dent in the epidemic we face of persons with mental illness entering justice systems.

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<u>Answer to question raised about mental health parity</u>

Michigan is one of only seven states without a parity law. This lets the private sector out of doing its fair share, and increases the burden on the public sector to whatever degree it can deal with that. Prior to implementation of a comprehensive parity law in North

Carolina, a survey of CMHs there found that the collective statewide burden to the public sector from lack of parity was $56 million annually.

We have had a federal parity law since 2008 (taking effect 2010), but it doesn't cover all employers (we estimate 1.5 million otherwise privately insured Michiganians left out), and the law has been hampered by the lack of final federal rules for it some four years after passage.

Under the federal Affordable Care Act, products available through state health insurance exchanges (beginning 2014) will be under requirement to meet the 2008 federal parity law. But it remains to be seen how that works out – the benchmark plan Michigan has submitted for minimum health insurance exchange offerings does not meet parity. Who will be responsible for fixing that, and how can the public be assured it has indeed been fixed? Furthermore, it is too early to know how many Michigan residents (both currently insured and presently uninsured) will wind up in the health insurance exchanges.

The bottom line is that parity represents the only practical hope for intervening with more people in the early stages of high-risk mental health conditions. And Michigan will not be able to do that to the fullest extent without a state parity law to supplement current and coming federal procedures.