MENTAL ILLNESS AND THE COURTS

BY HON. DAVID A. HOORT

"[T]he question of whether sick people are to be treated for their illness or punished for it, is a question which touches the very heart of judicial consciousness of a civilized system of jurisprudence." [1]

Michigan courts struggle daily with persons suffering from mental health issues. Whether it be frustrated family members requesting an involuntary commitment or a personal protection order (PPO) because of their inability to deal with mental illness in their child, spouse, or extended family member or mental illness as a factor in the Child Custody Act[2] or in the commission of a crime, the family and criminal courts encounter persons affected by mental illness on a consistent basis. Unfortunately, other than "legalized" forced segregation, Michigan law too often limits what families, the community, law enforcement, and mental health professionals can do, and those with varying degrees of mental illness end up homeless, incarcerated, or victims of violence or suicide instead of receiving help. All of this has been exacerbated by the closing of state psychiatric hospitals, the reduction in the availability of private psychiatric hospital beds, and the correlating stopgap measure of incarceration.[3]

The purpose of this article is not to unduly react to the Tucson, Arizona, shootings in 2011, during which an allegedly "mentally ill" person killed a federal judge and a 9-year-old girl and injured 14 others, including Congresswoman Gabrielle Giffords, who suffered a gunshot wound to the head and serious brain injury. Nor is it meant to be an explanation for the recent massacre of 16 Afghan civilians, including women and children, allegedly by a 38-year-old Army staff sergeant. Nor is it to advocate wholesale legislative reform or structural changes in Michigan's Mental Health Code. Rather, its purpose is to argue that sometimes to make the system work, "no" is not an acceptable answer.

FAST FACTS:

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Persons with mental illness are too often subject to insurance-related obstacles over and above what would be required of them if they were seeking treatment for some type of physical disability such as diabetes, heart disease, or hypertension.

Society has long accepted (and at times advocated) relief for its citizens that comes in the form of isolating or separating persons with mental illness from the general community, ranging from the dungeon to the county farm and insane asylum or mental hospital to today's PPO or incarceration. In the Dark Ages, those living with mental illness were blamed for their condition and, because of concomitant religious intolerance, thought to be possessed by the Devil and morally depraved. They were not treated, but were instead killed, tortured, or imprisoned.[4] By the nineteenth century, this extreme approach had given way to a more enlightened, but continued segregationist, response. Persons afflicted with a mental illness were sent away, ostensibly for life. Those without financial resources were removed from society and placed in publicly funded, questionably appropriate, facilities such as the county farm or state mental hospital.[5] At one point, more than 422,000 individuals were "hospitalized" for psychiatric care in the United States.[6]

In the late 1900s, mass deinstitutionalization of mental health care with managed care, short-stay hospitalization, and treatment within the community became the standard method for treating mental illness. Unfortunately, economic realities often left patients and their families to their own resources because of a lack of available or affordable outpatient programs for rehabilitation and reintegration back into society.[7] In 1850, there was approximately one public psychiatric bed available for every 5,000 people. By 1955, this number had improved to approximately one bed for every 300 people in the United States. In 2004, with deinstitutionalization, the number of beds fell back to the mid-1800s level of one for every 3,000 people. A 2009 University of Michigan study of 618 persons incarcerated with the Department of Corrections (which did not include inmates who were too impaired by their mental illness to consent to participating in the study) found that 20.1 percent of men and 24.8 percent of women in Michigan prisons have severe mental health symptoms.[8] The Los Angeles County Jail, the Cook County Jail in Chicago, and Riker's Island in New York City each hold more people with mental illness on any given day than any hospital in the United States.[9] Compare this with a study that reported that there were 0.7 percent "insane persons" in jail and prisons in 1880[10] and that 1.5 percent of arrestees were psychotic at the time of arrest in a 1930 study.[11]

What about today? If a person is afflicted by some degree of mental illness, what alternatives are available or in use in Michigan? Consider the many examples under Michigan law that involve segregation rather than treatment. Michigan law allows the family division of the circuit court to enter a PPO to enjoin certain unwanted or unacceptable behavior, including prohibitions on contact, conduct, and mobility.[12] It is therefore not unusual (and allowable under the statute) for family members or persons in the community to request PPOs against those afflicted with a mental illness, the alternative being that those with a mental illness may otherwise be harmed or harm a family member, stranger, or police officer.

In a local example, I issued a PPO in response to a mother's desire to protect her children from their father's mental health issues and fits of violence. In this case, her initial attempts to get him help were unsuccessful. The response from the psychiatric facility was to threaten to call protective services if he did not voluntarily admit himself into the hospital. (The disadvantage in a "voluntary" commitment is the ability of a person to check himself out of the hospital and the lack of any mandatory follow-up.) After the father was "voluntarily" committed, he then checked himself out and, after being released from the psychiatric hospital, physically assaulted his wife. As in the criminal justice system, with our use of incarceration as a substitute for mental health services, the unsuccessful voluntary commitment and the following assault by the father upon his release from the psychiatric hospital resulted in the mother obtaining a PPO to hopefully protect herself and her children.

For determining the "best interests of the child," the Child Custody Act lists several factors for the court to consider and evaluate when deciding custody and parenting time. They include factor (g), the "mental and physical health of the parties involved."[13] Although only one factor, it may be determinative in the placement of a minor child.[14] A 1990s study of 322 women with persistent severe mental illnesses found that women with a diagnosis of persistent severe mental illness, schizophrenia, schizoaffective disorder, bipolar disorder with or without psychosis, or major depression with or without psychosis were increasingly subject to the termination of their parental rights to their children. Women with these mental illnesses were also consistently found to be at increased risk of losing long-term or permanent responsibility for their children's care.[15]

In 1994, Michigan changed the dynamics of mental illness in the criminal justice system by modifying the procedural aspects of legal insanity, making it an affirmative defense. A defendant who wishes to use legal insanity as a defense to otherwise criminal conduct must prove that he or she lacked substantial capacity

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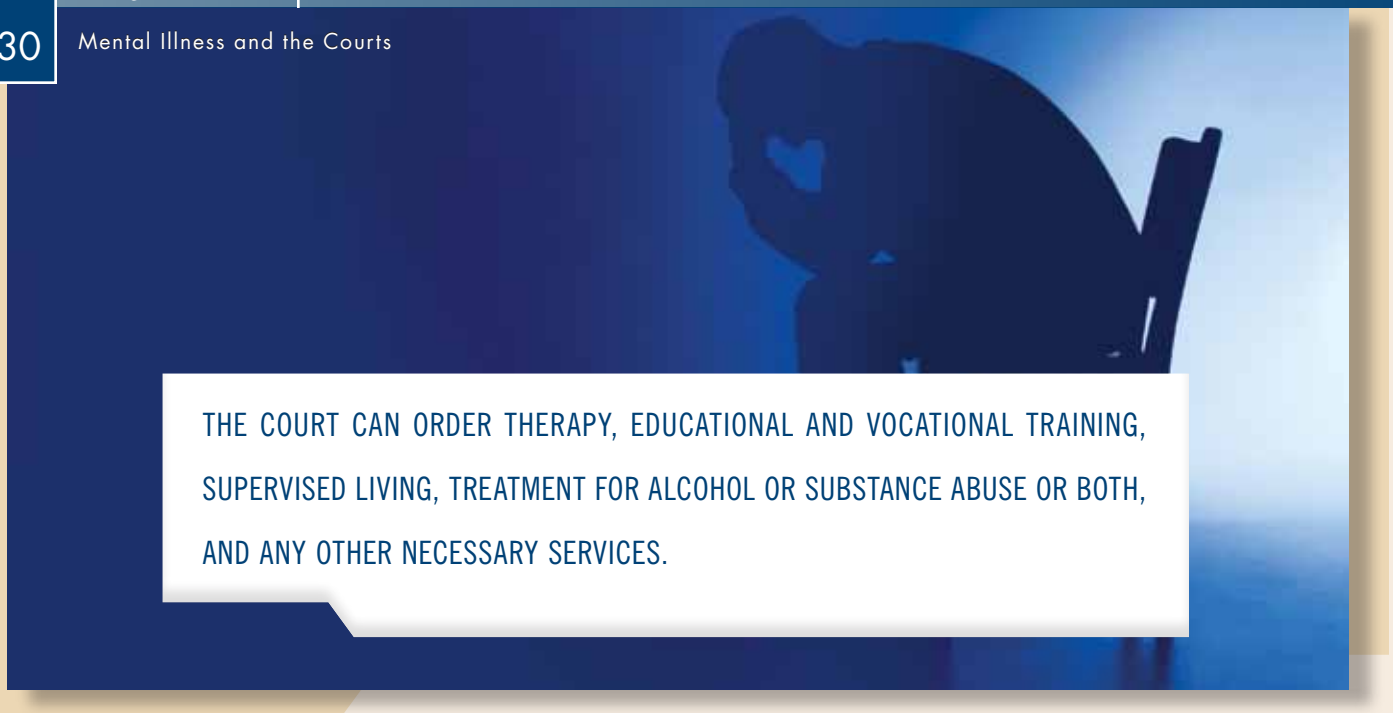

THE COURT CAN ORDER THERAPY, EDUCATIONAL AND VOCATIONAL TRAINING, SUPERVISED LIVING, TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE OR BOTH, AND ANY OTHER NECESSARY SERVICES.

to either appreciate the nature and quality or the wrongfulness of his or her conduct or conform that conduct to the requirements of the law.[16] Is it surprising, then, that in Michigan there are more mentally ill people who are homeless or in jail than there are mentally ill persons in psychiatric hospitals?[17]

The Mental Health Association in Michigan reports that 1.4 million Michigan adults have some form of mental illness.[18] Although there is an expanded ability to treat persons because of advanced therapies and more effective drugs, many individuals with varying degrees of mental illness are not getting treatment. Those with a mental illness are too often subject to higher insurance co-pays and deductibles, limited outpatient treatment coverage, and lower caps on lifetime benefits. They often face obstacles over and above what would be required of them if they were seeking treatment for some type of physical disability such as diabetes, heart disease, or hypertension.[19] And too often the "system" administratively denies treatment to persons with a mental illness who would seem to qualify under the Mental Health Code for court-ordered treatment because they pose a danger to themselves or others. Notwithstanding an otherwise factual basis for a petition for an involuntary commitment, a community mental health agency may be unwilling to allow an evaluation if the triggering incident occurred more than 24 hours before, if the person was incarcerated, if the mentally ill individual just "promises not to hurt himself," or if in the lay opinion of the community health agency staff the person is not mentally ill or a danger to himself or others.

Now consider the current statutes relating to treatment of persons with mental-health-related concerns. What is available as a viable alternative to, or in conjunction with, jail, prison, PPOs, or losing parental rights? For involuntary treatment, an individual must be mentally ill and a "person requiring treatment" as defined by the Mental Health Code. Mental illness is defined as "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life."[20] To be a person requiring treatment demands proof of one of the following:

- That because of mental illness the person could reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or herself or another individual and has engaged in acts or threats that support this expectation.
- That as a result of mental illness the individual has demonstrated the inability to attend to his or her basic physical needs that must be addressed for that person to avoid serious harm in the near future..
- That the mentally ill person's judgment is so impaired that he or she is unable to understand the need for treatment and his or her continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to that person or others.[21]

In 2005, legislation was also enacted in Michigan to allow the probate court to order involuntary assisted outpatient treatment for individuals who are mentally ill and have stopped or are unwilling to continue mental health counseling.[22] This legislation, known as Kevin's Law, increased significantly the ability of the courts to help and protect families and the community by requiring those with mental illness to participate in assisted outpatient treatment.[23] Kevin's Law enables a community mental health agency to set up by court order a program of mental health treatment using a wraparound approach with provisions, if needed, for alcohol and substance abuse. Kevin's Law allows the probate court to order an individual to take medication or submit to blood or urine testing. The court can also order therapy, educational and vocational training, supervised living, treatment for alcohol or substance abuse or both, and any other necessary services to assist that person or to prevent a relapse or mental-health-related deterioration.[24] In New York, similar legislation over a five-year period resulted in

74 percent fewer cases of homelessness, 77 percent less psychiatric hospitalization, 83 percent fewer arrests, and an 87 percent reduction in the use of incarceration.[25] In just one year, a similar law in North Carolina resulted in a reduction in arrests of persons with a prior history of multiple hospitalizations from 45 percent to 12 percent after use of assisted outpatient treatment.[26]

But if there are inpatient and outpatient treatments available by statute for those who are mentally ill and requiring treatment, why then are there persons afflicted with mental illness who continue to go untreated, remain homeless, or fall through the cracks and into our criminal justice system and incarceration at an unacceptable rate?[27] Why do we allow individuals with mental illness to die in our jails?[28] The answer lies in a well-intended desire to provide community treatment to those with severe mental illnesses and a corresponding lack of available funding.

In Michigan, community mental health agencies are ostensibly prohibited from providing services to persons in need of treatment unless the mental illness constitutes a serious mental illness.[29] This administrative use of a severe and persistently restrictive qualifier precludes funding and services, notwithstanding existing Michigan law[30] otherwise requiring treatment for persons who are mentally ill and a danger to themselves or others or unable to provide for their daily needs. In another local example, this resulted in a contracting mental health agency simply refusing to comply with a court order requiring a person to be evaluated for a possible involuntary commitment. However, I would submit that even if there is an arguably allowable preference in treatment related to the severity of the mental illness, the clear language of the Mental Health Code does not allow for "serving or funding the specified populations or services *to the exclusion of other populations or services.*"[31] Any preference in treatment should not preclude courts from following the statutory directive to order an evaluation, involuntary inpatient, or outpatient treatment under the Mental Health Code.

If by semantics or otherwise we continue to deny mental health treatment, we repeat and continue the forced segregation our forbears engaged in as the treatment of persons living with a mental illness. The difference is that instead of the village elders deciding what is evil, we have legislated or administratively decided what services will be provided to those in need of mental health treatment. The resulting judicially and statutorily legalized, forced isolation through personal protection orders; denial of evaluations, inpatient treatment, or assisted outpatient treatment; and the use of jails and prisons is and should be regarded as unacceptable. ■

Judge David A. Hoort is a 1978 graduate of Thomas M. Cooley Law School. As district judge, he established a state-acclaimed Day Reporting Program for Alcohol offenders and was recognized by the state of Michigan for his efforts on behalf of families affected by domestic violence. During his tenure with the circuit court, Judge Hoort initiated the state's first mental health court for felony probationers, authored spousal guidelines for domestic relations cases, and in 2008 was honored by the State Bar of Michigan as a Champion of Justice.

FOOTNOTES

1. *People v Griffes,* 13 Mich App 299, 306; 164 NW2d 426 (1968).
2. MCL 722.21 *et seq.*
3. See Treatment Advocacy Ctr, *The Shortage of Public Hospital Beds for Mentally Ill Persons* (2008), available at <http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf>. All websites cited in this article were accessed May 22, 2012.
4. State of New Jersey Governor's Council on Mental Health Stigma, *The Evolution of Stigma* <http://www.state.nj.us/mhstigmacouncil/about/evolution>.
5. *Id.*
6. St. Rosemary Educational Institution, *History & Causes of Mental Illnesses* (December 22, 2010), available at <http://schoolworkhelper.net/2010/12/history-causes-of-mental-illnesses/>.
7. *Id.*
8. Fries, *Independent Study of Mental Health and Substance Abuse: Final Report,* Report to the Michigan Legislature (February 10, 2010), p 3, available at <http://www.michigan.gov/documents/corrections/2010_Boilerplate_302_Final_Version_316653_7.pdf>.
9. Torrey, *Reinventing Mental Health Care,* City J (Autumn 1999), vol 9 no. 4, available at <http://www.city-journal.org/html/9_4_a5.html>.
10. United States Department of the Interior, *Report on the Defective, Dependent, and Delinquent Classes of the Population of the United States* (1888), available at <http://www2.census.gov/prod2/decennial/documents/1880a_v21-01.pdf>.
11. Bromberg & Thompson, *The relation of psychosis, mental defect and personality types to crime,* 28 J Crim L & Criminology 70, 88 (1937).
12. See MCL 600.2950 *et seq.*
13. MCL 722.23(g).
14. See *Bowler v Bowler,* 355 Mich 686, 695; 96 NW2d 129 (1959).
15. Hollingsworth, *Child custody loss among women with persistent severe mental illness,* 28 Ox J 199, 209 (2004).
16. MCL 768.21a; *People v Carpenter,* 464 Mich 223, 230–231; 627 NW2d 276 (2001).
17. Torrey & Zdanowicz, *Kevin's Law Would Help Treat Mental Illness, Prevent Tragedy,* Detroit Free Press, August 8, 2001, available at <http://www.treatmentadvocacycenter.org/index.php?option=com_content& task=view&id=546&Itemid=203.>
18. Mental Health Association in Michigan, *Michigan Community Mental Health Services* <http://www.mha-mi.com/backgrd.html>.
19. Editorial, *Equitable treatment for Michigan's mentally ill,* Grand Rapids Press, June 25, 2009, available at <http://www.mlive.com/opinion/grand-rapids/index.ssf/2009/06/editorial_equitable_treatment.html>.
20. MCL 330.1400(g).
21. MCL 330.1401(a) through (c).
22. MCL 330.1401(1)(d).
23. MCL 330.1433; MCL 330.1469(a).
24. MCL 330.1433(3).
25. New York State Office of Mental Health, *Kendra's law: Final report on the status of assisted outpatient treatment* (2005), available at <http://bi.omh.ny.gov/aot/files/AOTFinal2005.pdf>.
26. Swanson *et al., Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness,* 176 Brit J Psychiatry 224, 231 (2000).
27. United States Department of Justice, *Criminal Justice/Mental Health Consensus Project* (2002), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>.
28. *Perez v Oakland Co,* unpublished opinion per curiam of the Court of Appeals, issued March 27, 2007 (Docket No. 271406).
29. MCL 330.1116.
30. MCL 330.1401.
31. MCL 330.1100c(6) (emphasis added).