Report on Public Policy Position

Name of Section:
Judicial Conference

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Bill Numbers:
SB 199 (Brater) Criminal procedure; other; diversion from jail for certain individuals under certain circumstances; amend code of criminal procedure to allow. Amends 1927 PA 175 (MCL 760.1 - 777.69) by adding sec. 85 to ch. VII. TIE BAR WITH: SB 0200'07
SB 200 (Brater) Mental health; other; priority for providing mental health services to individuals diverted from jail; require under certain circumstances. Amends sec. 208 of 1974 PA 258 (MCL 330.1208). TIE BAR WITH: SB 0199'07

Date position was adopted:
March 2, 2007

Process used to take the ideological position:
Position adopted after discussion and vote at a scheduled meeting

Number of members in the decision-making body:
27

Number who voted in favor and opposed to the position:
9 Voted for position
0 Voted against position
0 Abstained from vote

Position:
Support and offer amendments

Explanation of the position, including any recommended amendments:
See attached.

The text (may be provided by hyperlink) of any legislation, court rule, or administrative regulation that is the subject of or referenced in this report:
http://legislature.mi.gov/doc.aspx?2007-SB-0199
http://legislature.mi.gov/doc.aspx?2007-SB-0200

EXECUTIVE SUMMARY
THE CASE FOR MENTAL HEALTH REFORM
FROM A JUDICIAL PERSPECTIVE

Our jails and prisons are filled with people whose only real crime was not to get timely treatment for their mental illness. Behind that criminal behavior are avoidable victims, if only we would provide timely treatment.

If we treated small pox the way we treat mental illness, we would stop vaccinating and instead build small pox treatment centers across Michigan.

Mental illness should be treated like any other illness, and that means intervening when the individual lacks the capacity to make an informed decision about their illness. For all other illnesses, a third party can be given the power to consent to treatment if the patient does not have the capacity to make an informed decision. For mental illness, involuntary treatment for that illness requires more than a lack of capacity, danger to self or others must also be shown.

A person with a mental illness, who is incapacitated, may receive involuntary treatment for any illness, except mental illness. A guardian may make end of life decisions, permanent placement decisions, and decisions about amputation and other major decisions; but, the guardian may not consent to involuntary mental health treatment that would restore capacity and avoid harm such as homelessness or incarceration.

The current Mental Health Code is an in-patient model in an out-patient world. It seeks to prevent unnecessary hospitalization, which in a managed care era of downsized mental health beds is really no threat at all.

We recommend that you support legislation to align the Mental Health Code with current treatment practices and treat mental illness like any other illness to help restore capacity and to reduce crime, homelessness and stigma.

The failures of the current system touch all of us. These reforms are simple, will save money, can be done quickly and will be enthusiastically received by all who have experienced the frustration of obtaining help for those unable to help themselves.

SUGGESTED LEGISLATIVE REFORMS

- **Change criteria for involuntary treatment to: "An individual who has mental illness and lacks sufficient understanding or capacity to make or communicate informed decisions concerning their mental illness."**

- **Permit the court to authorize a guardian of an incapacitated individual to consent to involuntary treatment.**

- **Provide that the court order for involuntary treatment would be for 180 days and would be directed by the community mental health service program and would coordinate outpatient/inpatient care.**

- **Provide for permanent enhanced access status to persons who meet uniform statewide criteria for severity as recommended by the Michigan Mental Health Commission.**

- **Fully implement the hierarchy of choice as recommended by the Michigan Mental Health Commission.**

These legislative reforms will advance the first two goals of the Commission:

Goal 1: The public knows that mental illness and emotional disturbance are treatable, recovery is possible, and people with mental illness and emotional disturbance lead productive lives.

Goal 2: The public mental health system will clearly define those persons it will serve and will address the needs of those persons at the earliest time possible to reduce crisis situations.

ISSUES AND TRENDS IN MENTAL HEALTH LAW

Excerpts from presentation on June 13, 2006
Michigan Probate Judges Association 110th Annual Conference

Hon. Milton L. Mack, Jr.
Chief Judge, Wayne County Probate Court

HISTORY

Before getting into issues and trends in mental health law, it is useful to establish where we are and how we got there.

In 1960, the population of the United States was 180,000,000. Nationally, state mental hospitals housed over 559,000 people. At the same time, Michigan's population was 7.8 million with over 20,000 people in its mental hospitals.

Today, the population of the United States is nearing 300,000,000, while the number of persons in state mental hospitals has declined to 50,000. Michigan's population has grown to 9.9 million, but less than 1,000 people are in state mental hospitals.

So, how did this happen? A media exposé of living conditions of the mentally ill by ABC News seems to have helped trigger the passage of the Community Mental Health Act in 1963. A key feature of the Act was the agreement of the federal government to pay for the treatment of persons experiencing mental illness, *unless* they were adult patients in a state or private mental hospital. This created a huge incentive for legislators to deinstitutionalize patients in order to shift the responsibility for paying for the care of these patients to the federal government. The report of the Michigan Mental Health Commission in 2004, found that the federal government's new role, as well as more effective psychotropic medicines and advances in therapy, caused the dramatic decline in involuntary hospitalization. The Mental Health Commission found that during this same time, jail populations saw a dramatic increase in the number of persons with mental illnesses. We were

successful at deinstitutionalization; we were not so successful at planning for the delivery of mental health services outside the hospital.

UNINTENDED CONSEQUENCES

Michigan, like most states, has maximized its general fund dollars to bring in federal dollars. This has caused the shift of nearly all general fund dollars to provide services to those who are Medicaid-eligible, leaving little to serve the rest of Michigan's population. While this does maximize the receipt of federal dollars, for those who are not Medicaid-eligible and lack private insurance coverage for mental illness, they are often not able to access the system. The funding transfer has changed Michigan from a public mental health system to a Medicaid mental health system. To further compound the problem, now that we are totally reliant on Medicaid for mental health, the federal government is taking steps like the Deficit Reduction Act of 2005 to pull back on Medicaid funding and availability.

One of the curious consequences of this change in funding is to force a patient who has successfully been restored to competency to avoid gainful employment in order to preserve access to care. The result of all of this is that timely and clinically appropriate intervention is not available when it would be most effective. The Commission found that we have been left with a state/community mental health system that is uncoordinated and fragmented, with few real quality controls and dispersed accountability.

The current system fosters an unacceptably wide variation in funding, quality of care, rights protection and promotion, and access to care, and suffers from administrative redundancy and unproductive variance in payer reporting requirements. While the evidence is strong that people with mental illness benefit from early intervention, the system lacks the capacity to respond in a

timely manner for far too many people diagnosed with a serious mental illness. So how is it that the system is so misaligned?

MISALIGNMENT OF SYSTEM AND SCIENCE

The Mental Health Code, as it relates to involuntary treatment, is an in-patient model in an out-patient world. By that I mean that the delivery of mental health services has shifted dramatically over the last 40 years from an in-patient model to an out-patient model; yet, the primary focus of the Mental Health Code seems to be preventing anyone from being unnecessarily involuntarily hospitalized. In Wayne County, where inpatient mental health care is paid for on a managed care basis and the average length of stay is less than 5 days, the real risk to persons suffering from mental illness is that they will not get the care they need when it would do them the most good. Twenty years ago, hospitals were paid on a cost-plus basis which did not create any sense of urgency to discharge a patient as soon as possible. Now, hospitals are paid on a per case basis creating a financial incentive to make stays as short as possible.

This shift to out-patient care has meant that the vast majority of people served by the mental health system never come to the attention of the probate court. At last count, in Wayne County, only 10% of those receiving services from community mental health were the subject of a petition. On the other hand, 15% of the inmates of the Wayne County Jail had a case history with the Wayne County Probate Court. The current in-patient focus of the mental health code simply fails to recognize the fact that we live in an out-patient world with very short hospital stays.

The current statutory progressive hospitalization orders of 60 days, 90 days, and one year are irrelevant in a managed care era where inpatient hospitalization is measured in tenths of a day and is currently under 5 days. This alone speaks volumes about the disconnect between the system and

science. Likewise, having judges make clinical judgments as to how many days of inpatient hospitalization and outpatient treatment are required is misguided at best.

Recent legislative efforts like Kevin's Law are examples of the legislature recognizing that the system does not work. But, even this effort falls far short of what is necessary to properly align the Mental Health Code with today's evidence-based best practices for delivering mental health care.

By way of example, in 1979, the legislature clarified the definition of legally incapacitated person by adding language to require a finding that the person "lacks sufficient understanding or capacity to make or communicate informed decisions concerning his or her person." This clarified that it was the capacity of the person and not the conduct of the person that would drive the decision as to whether to appoint a guardian. Unfortunately, the Mental Health Code tends to focus on conduct and Kevin's law continues that practice. Among the requirements for ordering assisted outpatient treatment is the individual's placement in a psychiatric hospital, prison, or jail at least two times within the previous 48 months or whose noncompliance with treatment has been a factor in the individual's committing one or more acts, attempts, or threats of serious violent behavior within the last 48 months. Aside from finding witnesses competent to testify as to prior behavior, the focus is on conduct and not capacity. The fact that so few petitions for assisted outpatient treatment are filed is a testament to their lack of usefulness.

Another recent legislative initiative that recognizes the disconnect between the Mental Health Code and science is SB 939 which relates to the Not Guilty by Reason of Insanity (NGRI) and Incompetent to Stand Trial (IST) population. This bill would create a distinct civil commitment process for NGRI and IST patients. The bill would modify the Mental Health Code to permit greater restrictions on the freedom of movement for those in the NGRI or IST class. It would relax the definition of mentally ill to include mental illness in remission that would likely

become active without continued treatment. The criteria for commitment would be met if the person has a mental illness and, without treatment, the individual would likely become dangerous to self or others. While this recognizes the shortcomings of the current Code, it is inadequate. It fails to respond until after the person in the NGRI or IST class has caused injury or damage. Why not design the system for everyone so that we can reduce the risk of harm for everyone?

The legislature's lack of understanding of this issue is reflected in its apparent attempt to permit a patient advocate to act under a durable power of attorney to consent to involuntary mental health treatment pursuant to the Estates and Protected Individuals Code (EPIC) (MCL 700.5509(1) (h)) without sufficiently modifying the Mental Health Code (MCL 330.1403) which clearly declares that individuals may only receive involuntary mental health treatment pursuant to the Mental Health Code. The Mental Health Code was modified to permit a patient advocate to execute a formal voluntary application for admission. However, the legislature did not change the language that permits the patient to object and prevent any further involuntary treatment for more than three days after the patient gives notice (MCL 330.1419). In addition, the legislature failed to authorize any other involuntary mental health treatment, such as out patient treatment. The net effect appears to only permit a patient advocate to impose three days of involuntary hospitalization.

Even more curious, the legislature amended EPIC (MCL 700.5306(5)) to apparently provide that the probate court could modify the powers of a patient advocate for mental health decisions to give that power to the guardian. The Mental Health Code, which by its terms is the exclusive method whereby a person may receive involuntary treatment was not amended. It appears that when the legislature amended EPIC it mistakenly assumed guardians had the power to consent to involuntary mental health treatment.

Consider the role of guardians of incapacitated adults. The court can appoint a guardian for a person who lacks the capacity to make informed decisions due to mental illness, but that guardian cannot be given the authority to consent to involuntary mental health treatment, unless the ward is also developmentally disabled (in which case, pursuant to the Mental Health Code, the court can give that power to the guardian).

The court may appoint a guardian for a person who is mentally ill and the guardian may consent to all kinds of treatment for all kinds of diseases, except mental illness. That guardian may also choose where the ward will live. The standard is fairly simple: Does the individual lack the capacity to make an informed decision?

On the other hand, if the ward is mentally ill and lacks the capacity to make an informed decision, treatment may only be imposed under limited circumstances. A far higher standard is required to provide the treatment necessary to restore the ward's capacity for independent decision-making. Before imposing mental health treatment for an individual who lacks the capacity to make an informed decision, we require that person to be in crisis. The same standard is not required for permitting a guardian to consent to treatment for any other illness.

If a person lacks the capacity to make an informed decision to treat their mental illness, how can we say that person has made a choice? One of the members of the Commission who had a history of mental illness informed the Commission that she had been involuntarily hospitalized three times and while she hated it at the time, she was convinced it saved her life.

We permit the guardian of an adult who cannot make informed decisions due to mental illness to consent to treatment for heart disease without waiting for a heart attack. Why do we require that same person to be in crisis to get treatment for their mental illness? We require crisis

even though we now know that repeated episodes of crisis weakens the individual's ability to respond effectively to treatment. In effect, this policy requires risking permanent incapacity.

Why treat the illnesses so differently? I would suggest that this difference in treatment is not only harmful to those experiencing mental illness, but it also serves to perpetuate the stigma associated with mental illness. Treating mental illness like any other illness would go a long way to reducing stigma. If you want parity for mental illness, then, treating mental illness the same as any other illness should be the first step towards achieving parity.

MENTAL HEALTH COMMISSION FINDINGS

A key finding of the Commission was that too often, people must be in crisis to receive mental health care. The Commission found that policy makers and the public fail to recognize that mental illness is a disease that is responsive to specific treatment, that recovery is possible, and that people with mental illness can lead productive lives. Ample evidence establishes that early intervention is effective and preserves the health and quality of life of persons with mental illness, saving costs in the long term because more intensive care is often unnecessary. Conversely, waiting until the person is in crisis impairs recovery and damages resiliency. The Commission found that the delay in the delivery of the right care at the right time has resulted in overuse of the juvenile and criminal justice systems as well as increased homelessness. The lofty goal of the Mental Health Code to limit restrictions on the freedom of movement of recipients of mental health services is lost when the recipient is jailed or left homeless because they did not receive timely treatment for their mental illness.

MENTAL HEALTH COMMISSION RECOMMENDATIONS

The Commission recommended the following new vision for Michigan in addressing the mental health needs of its citizens:

> *Michigan's children and adults enjoy good mental health and are served by a mental health system that responds effectively to the needs of individuals with mental illness and emotional disorder while promoting resiliency and recovery.*

The Commission also identified a series of seven values and seven goals to transform Michigan's mental health system. The Commission made 71 specific recommendations to advance the vision, values and goals identified by the Commission.

I plan to focus on Goal 2 and several of those recommendations because I think they are the most relevant to our work as probate judges and would solve the misalignment problem we experience as judges.

GOAL 2: THE PUBLIC MENTAL HEALTH SYSTEM WILL CLEARLY DEFINE THOSE PERSONS IT WILL SERVE AND WILL ADDRESS THE NEEDS OF THOSE PERSONS AT THE EARLIEST TIME POSSIBLE TO REDUCE CRISIS SITUATIONS.

It is generally recognized that the likelihood of successful treatment is greater when persons with mental illness choose to be treated and have ownership of the decision. At the same time, intervening earlier in the onset of symptoms improves the possibility of full recovery and preserving resiliency. To that end, the Commission recommended that the legislature implement a hierarchy of intervention, described as a hierarchy of choice. The hierarchy of choice begins with voluntary treatment and continues with advance psychiatric directives, followed by involuntary treatment and finally, granting guardians the authority to consent to involuntary treatment.

The goal of the hierarchy would be to make every effort to avoid involuntary treatment unless the consumer's understanding of his or her need for treatment was impaired to the point that the individual would be at risk for significant physical harm to self or others in the near future.

The hierarchy is organized to reflect that a number of tools need to be in the toolbox in order to provide the right care at the right time. Where possible, facilitative mediation would be employed to achieve consumer ownership of the process. Facilitative mediation is important because it gives people with mental illness ownership of the decision and therefore is more likely to achieve compliance and recovery.

At each step along the hierarchy and every onset of symptoms, individuals should have the opportunity to begin at the top of the hierarchy, even if there is a guardian in place. The top of the hierarchy provides the greatest opportunity for choice by the consumer which translates into greater ownership of the treatment plan, increased compliance and a greater likelihood of success.

The decisions or steps that would make up the hierarchy of choice include:

Voluntary

This is the preferred option. It maximizes the ability of the consumer to choose, and therefore maximizes the likelihood of compliance and recovery.

Advance Psychiatric Directive

In this case, the consumer has at least identified the person to make choices on his or her behalf. In 2004, the legislature did enact legislation to provide for advance psychiatric directives. The language is complex, confusing, and not in sync with the Mental Health Code. It fails to achieve the fundamental goal of the advance directive, which is to permit a person of their choosing to act on their behalf to secure any appropriate involuntary mental health treatment.

Involuntary

Involuntary proceedings would be available if treatment could not be initiated either voluntarily or by way of an advance psychiatric directive. The process would begin by giving the

patient a second opportunity to be a voluntary patient. Failing that, a deferral conference and a waiver and consent would be available.

In the absence of consent, a trial would be conducted which would include the right to an independent medical examination, appointed counsel and a jury trial. However, instead of the progressive 60 day, 90 day, or one year continuing order process, if the court found that the respondent was a person requiring treatment, the court would enter an order for involuntary treatment for up to 180 days with the community mental health service program directed to coordinate outpatient and inpatient care as clinically necessary. Judges would not make clinical decisions as to how much time a patient should spend in the hospital. Having judges make clinical decisions, including what medicine to take, as in Kevin's law, perpetuates the problem of treating mental illness different than other illnesses. We do not decide how long an incapacitated adult will be in the hospital for heart disease or what kind of medicine will be prescribed. Clinical decisions should be left to those trained in that field. We should simply decide whether the person has the capacity to make an informed decision about treating their mental illness.

Guardianship

Finally, if the consumer has a guardian, has a history of involuntary treatment, and lacks the capacity to execute an advance psychiatric directive, the guardian would be permitted to petition the court for authority to consent to involuntary treatment. Currently, only the guardian of a person with developmental disabilities may petition the court for that authority.

An important component of this hierarchy would be to modify the definition of those requiring involuntary treatment in order to get them into care more quickly when the care can be more effective in promoting long term recovery and resiliency.

MCL 330.1401(1)(a)(b) and (c) set out the current criteria for involuntary inpatient treatment. The definition of "a person requiring treatment" is a legal not a medical definition. A person might require treatment according to a physician but not meet the criteria of the Mental Health Code. For example, the Commission found that subsection (a) is often interpreted to mean that an individual must be threatening homicide or suicide to be considered for a petition. A person could be found to be mentally ill and be reasonably expected in the near future to seriously injure someone, but if that individual has not engaged in a specific act or made "significant" threats to support that expectation, then that person does not require treatment under the Mental Health Code. Subsection (b) focuses on the ability of the person to attend to basic needs to avoid serious harm. Some harm is apparently permissible. Subsection (c) is particularly curious in that it can only be used on a petition for treatment and not an application. Under subsection (c), the facts are less important than who initiates the process. The hospital, which must file an application and not a petition, is not permitted to seek involuntary treatment under subsection (c). So, if a person needs treatment pursuant to subsection (c), they can only get that treatment if someone other than the hospital files a petition. Does the identity of the applicant make a difference in assessing a patient's need for treatment? These criteria are strongly inpatient focused and prevent timely intervention when it would do the most good.

The Commission recommended reorganizing and restating the criteria to call for greater attention to the options presented by (b) and (c). The proposed language reads as follows:

> "A person requiring treatment is an individual who has mental illness and as a result of that mental illness represents a danger to self or others, or an individual who has mental illness and without treatment of that mental illness can reasonably be expected, based on competent clinical opinion, to represent a threat to self or others in the near future because of inability to understand the need for treatment or attend to basic physical needs such as food, clothing, or shelter."

I would suggest we consider going even further and align treatment for mental illness with treatment for other illnesses. Why not provide that involuntary mental health treatment could be ordered for someone who has a mental illness and lacks the capacity to make informed decisions about their mental illness? We allow guardians to make much more invasive and dramatic decisions about a person's care, treatment and placement using that same standard. The Mental Health Code criteria are an anachronism in an outpatient world.

The goal of all of this is not to increase the number of petitions or the amount of hospitalization. Early intervention which relies on the extent of the ability of the consumer to make an informed choice should result in less hospitalization, less homelessness, and reduced use of the criminal justice system to manage persons with mental illness.

WHAT IS WORKING?

During 2005, Gateway Community Health and Detroit Receiving Hospital conducted a pilot program whereby a portion of the Severely & Persistently Mentally Ill (SPMI) population of Wayne County was diverted to a specialized emergency center instead of a medical emergency room. During a 14 week period, 346 cases were transferred to the Detroit Receiving Hospital emergency psychiatric department known as the DRH Crisis Center. Had these patients not been transferred, it is likely that all would have been admitted to the hospital where they had presented, followed by a petition for treatment. In fact, 92% of these patients had already been clinically certified by the emergency room physician prior to transfer to the DRH Crisis Center. On the other hand, of those who were transferred to the DRH Crisis Center, only 11% were hospitalized. A retrospective review found inappropriate and over utilization of physical restraints in the medical emergency rooms. The DRH Crisis Center model significantly reduced unnecessary and inappropriate psychiatric admissions and, while the average length of stay diminished, the re-

hospitalization rate did not increase. The project suggests that a specialized emergency room environment with a highly experienced and knowledgeable treatment team that has the time, interest, facility and expertise to fully evaluate the emergency at hand is better able to deliver the right care at the right time.

For these 346 patients, the difference in diagnosis and therefore quality of care and outcome was dramatic. One hundred sixty of those patients seen in medical emergency rooms were diagnosed with depression. The crisis center made that diagnosis in only 49 cases. The emergency rooms found substance abuse and mental illness in 44 cases while the crisis center found substance abuse with mental illness in 182 cases. Identifying the correct problem goes a long way towards obtaining the optimum outcome.

For those consumers who were re-directed to the specialized emergency room, a substantial majority not only received care more appropriate than they would have received but, unnecessary hospitalization was avoided.

CONCLUSION

Michigan's mental health system for involuntary treatment remains a confusing, uncoordinated, unaccountable and irrelevant inpatient model in an outpatient world. Patchwork legislation like Kevin's Law, while well-intentioned, simply fails to address the problem. Similarly, legislation like SB 939 recognizes the failure of the current model by carving out a different model for persons found not guilty by reason of insanity. Why not fix the problem for everyone? In some ways this legislation makes the problem worse by creating a false sense that the problem has been fixed. The recommendations of the Mental Health Commission, in conjunction with evidence-based best practices will give persons with mental illness a better opportunity for resiliency and recovery as well as becoming productive members of society.

We owe it the citizens of our state who suffer from mental illness to construct a mental health system that is aligned with science to work for them.