Changing Focus: The Right to Treatment of Serious Mental Illness

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Outline

- Serious Mental Illness: disabling aspects
- Brief overview of the history of involuntary treatment in the United States
- Standards and unintended consequences
- Justice involvement
- Assisted outpatient treatment: a potential resource
- Resources that should continue to expand
- Questions we must continue to address

Serious Mental Illness: Disabling Aspects

- Psychotic Disorders: Schizophrenia, schizoaffective disorder, bipolar disorder
- Hallucinations/delusions/paranoid thinking
- Problems interpreting the environment/reality testing
- Cognitive impairment:
- Poor ability to make decisions or to understand information
- Difficulty focusing or paying attention
- Anosognosia
- Symptoms or combinations of symptoms can be disabling with inability to care for oneself, rejection of acceptance of illness and refusal of care, and, in some cases, dangerousness

Consequences of Untreated Serious Mental Illness

- Over 11 million with serious mental illness; numbers with suicidality/homicidality/grave disability are relatively small but important
- 140,000 SMI homeless (250K with AMI are homeless) (HUD, 2015)
- 392,000 SMI incarcerated (265,455 SMI in prisons, 125,582 SMI in jails) (26,000 are for murder) (Glaze and Parks, 2012)
- 755,360 SMI on probation or parole (2,360,500 AMI on probation/parole) (Teplin et al., 2005)
- 25% of SMI (3 million) were victims of a violent crime in past year, 11X higher than the general population (Desmarais, et al., 2014)
- Lifetime risk of suicide: schizophrenia 5%; bipolar disorder 10-15% (K Hor and M Taylor, 2010)
- Lack of attention for physical health problems contribute to early death; on average 10 years earlier than the general population

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History of Commitment for Mental Disorders

- State has interest in protecting the vulnerable:
  - Parens patriae: responsibility of government to intervene on behalf of citizens who cannot act in their own best interest
  - Police power: Right to act on behalf of safety of all citizens including writing statutes to benefit society at large which may restrict individual rights
  - Physicians or other healthcare professionals often make that assessment in the case of mental illness

History

- U.S. History (1817-1824: First 4 asylums built in Northeast): institutionalization required only presence of a mental illness with a recommendation of need for treatment; resulting loss of liberty, rights, and property
- Because of abuses, standards changed to provide a right to legal representation and trial prior to coerced treatment and put such decisions with judges/magistrates
- Due to extremes in legal delays and loss of freedom while waiting; psychiatrists became involved with the decision around compulsory inpatient treatment in 1951 (Draft Act Governing the Hospitalization of the Mentally Ill from NIMH)
- 1950s: Over 550,000 in psychiatric hospitals

History

- Advent of effective antipsychotic medications in the 1950s leads to rejection of need for massive involuntary hospitalizations
- Advancement of the civil rights movement leads to push away from state mental hospitals to more humane treatment
- 1963: President Kennedy signs Community Mental Health Act which was to pave the way from state hospitalization to outpatient care and community living for those living with SMI
- Census of state hospitals drops to approximately 30,000 in the 1990s; massive closure of state hospitals

Commitment Standards Changed

- With deinstitutionalization the standard for commitment changed from need for treatment to **dangerousness (suicidality/homicidality that is imminent (close future event)) and grave disability (inability to provide for necessities for basic survival)**
- Legal rights defined through 1970s: Right to representation; right to hearing for hospitalizations longer than state requirements of days to up to 2 weeks
- Requirement of least restrictive level of care to meet needs of non-dangerous patients

Unintended Consequences: Where We Are Today

- Current commitment criteria make it nearly impossible to be admitted involuntarily to a hospital for inpatient care
- Families must watch loved ones who are non-violent decompensate to the point of being unable to care for themselves
- Marginalization of the mentally ill: homelessness, incarceration (often as a means of obtaining treatment due to short hospitalizations based on dangerousness criteria)

2016 National Survey on Drug Use and Health

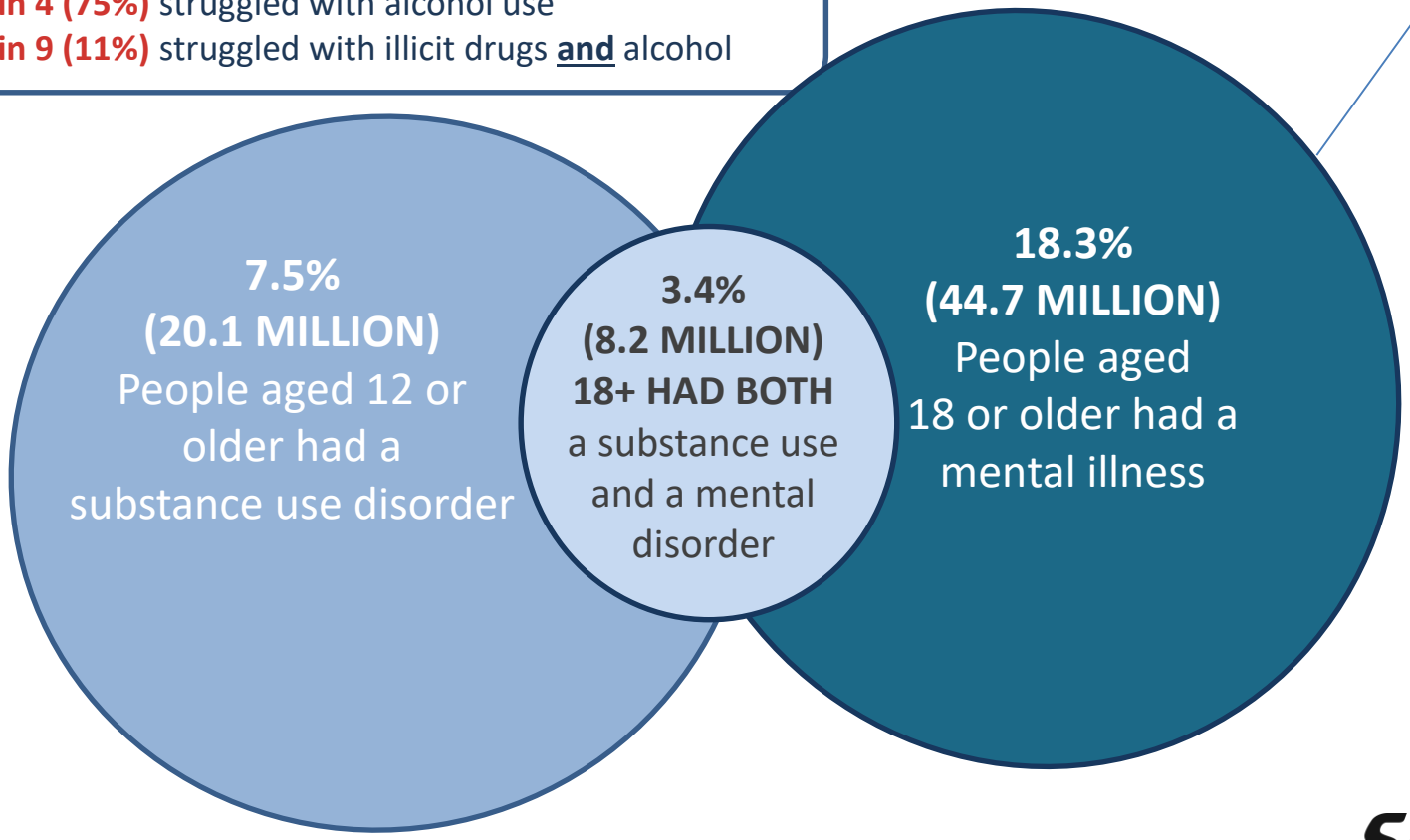
MENTAL AND SUBSTANCE USE DISORDERS IN AMERICA: 2016

Among those with a substance use disorder about:

- **1 in 3 (33%)** struggled with illicit drugs
- **3 in 4 (75%)** struggled with alcohol use
- **1 in 9 (11%)** struggled with illicit drugs **and** alcohol

Among those with a mental illness about:

1 in 4 (25%) had a serious mental illness



Over 2 million in jails and prisons
50% with SUDs
(http://www.prisonerhealth.org)
15-20% with SMI
Torrey EF, et al. 2014

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Issues in Justice Populations

- Reality in the United States: Large numbers with mental and substance use disorders incarcerated; few get treatment
- Failure of states to provide adequate mental health care and treatment for SUDs in community settings
- State civil commitment laws inadequate to provide necessary treatment/treatment duration
- There is a failure to use those laws to compel treatment for individuals at risk of harm to self or others
- Contributes to infractions/crimes that make it difficult for those living with SMI to be successful in communities

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Issues in Justice Populations

- Infractions committed while impaired by untreated mental illness
- Legal charges related to drug use
- Convictions make it much more difficult to get housing and employment leading to vulnerability for recidivism
- Transition from incarceration to release challenging in terms of ongoing mental health needs with frequent loss from treatment
- Anosognosia can make it difficult for a person to recognize their illness leading to non-adherence and cycling of adverse outcomes: unstable housing, justice involvement, risk for incarceration

Advances in Our Understanding of SMI

- Multifactorial etiology:
- Abnormal brain development
- Evidence for neurodegenerative process in schizophrenia: neuronal atrophy, progressive structural brain changes; genetic vulnerability
- Neurotransmitter abnormalities: glutamate/excitatory amino acid neurotransmission deficits that alter dopamine neurotransmission: medications development areas of focus
- Evidence for more refractory symptoms and more severe course of illness with increased duration of untreated psychosis
- Medications to address psychosis are also associated with improvement in cognitive function: attention, memory, learning
- Cognitive therapies have been developed that can assist a person in managing illness
- Peer supports can help people with SMI live in their communities
- Early intervention improves function and diminishes impact of illness
- *Why aren't we demanding that people with psychotic disorders have access to treatment?*

Potential Solutions: Addressing Untreated Serious Mental Illness in a Person with Dangerous Behavior with Assisted Outpatient Treatment

- A judge orders a person with serious mental illness to follow a court-ordered treatment plan
- Outcomes from New York (Civil commitment for SMI authorized through Kendra's Law):
  - 74% fewer participants experienced homelessness
  - 77% fewer experienced psychiatric hospitalization
  - 56% reduction in length of hospitalization
  - 83% fewer experienced arrest
  - 87% fewer experienced incarceration
  - 49% fewer abused alcohol
  - 48% fewer abused drugs
  - 81% said AOT helped them get and stay well

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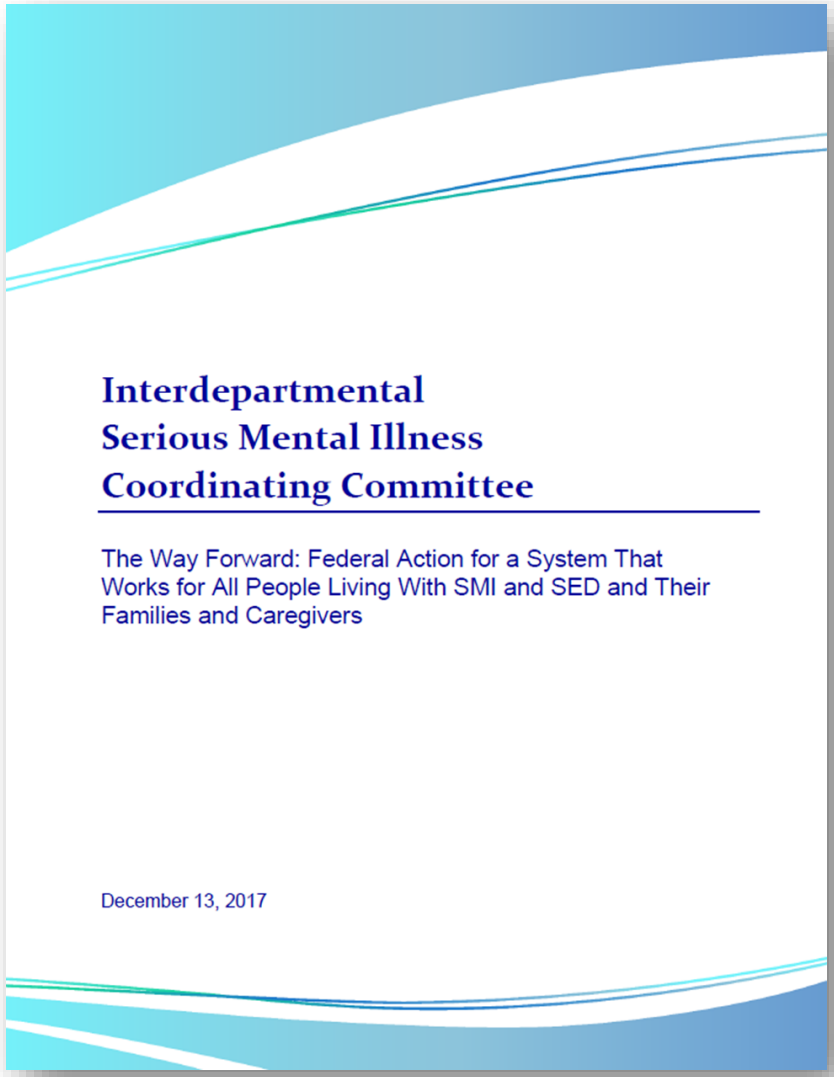
Addressing Serious Mental Illness Going Forward: Legislative Mandates


Interdepartmental
Serious Mental Illness
Coordinating Committee

The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers

December 13, 2017

- A review of the current state of treatment and recovery services for SMI/SED in the United States
- Recommendations by public members aimed at improving care and services
- Consideration and exploration of how federal departments that currently serve these populations might enact recommendations

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Report to Congress required:

- A summary of advances in serious mental illness (SMI) and serious emotional disturbance (SED)
- An evaluation of the effect federal programs related to serious mental illness have on public health
- 45 specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with SMI or children with SED organized into 5 focus areas

INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

- **Focus 1: Strengthen Federal Coordination to Improve Care**
  - Improve interdepartmental coordination; evaluate the federal approach to serving those with SMI/SED; use data to improve quality of care/outcomes
- **Focus 2: Access and Engagement: Make It Easier to Get Good Care**
  - Early identification and intervention for youth
  - Crisis intervention services development
  - Continuum of care with outpatient services as alternatives to inpatient care/psychiatric bed capacity
  - Reassessment of civil commitment standards and processes
  - Use of new technologies to increase access e.g., telehealth

- **Focus 3: Treatment and Recovery – Close the Gap Between What Works and What Is Offered**
  - Coordinated specialty care for first episode psychosis: FEP/CHR
  - Advance suicide prevention strategies: Zero Suicide
  - Make housing more available for people living with SMI/SED
  - Focus on development of integrated services for mental and substance use disorders; physical healthcare: CCBHCs/integrated care at FQHCs

- **Focus 4: Increase Opportunities for Diversion and Improve Care for People With SMI and SED Involved in the Criminal and Juvenile Justice Systems**
  - Train first responders on how to work with people with SMI/SED
  - Sustain therapeutic dockets in federal, state, and local courts
  - Universal screening for mental disorders, substance use disorders, and behavioral health needs for each person incarcerated
  - Reduce barriers that impede immediate access to treatment and recovery services on release

- **Focus 5: Develop Finance Strategies to Increase Availability and Affordability of Care**
  - Eliminate financing practices that discriminate against behavioral healthcare
  - Enforce existing parity laws
  - Pay for psychiatric and other behavioral health services at rates comparable to those for physical health problems
  - Provide reimbursement for outreach/engagement services related to mental health care
  - Expand the Certified Community Behavioral Health Clinic model nationwide

INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE

- Report sets the stage for work by HHS and other federal government departments in the years ahead
- In the immediate future, the ISMICC will help to prioritize recommendations and will continue to meet on a routine basis to provide guidance as necessary to assist in addressing the recommendations in this report
- Overall goal is to improve the health and welfare of those living with serious mental illness

SAMHSA Justice Programs: Mental Illness

- **Adult and Youth Treatment Court Collaboratives:**
  - Programs supporting local courts with greater flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers
  - Focuses on connecting with individuals early in their involvement with the criminal justice system and prioritizing the participation of municipal and misdemeanor courts in the collaborative
- **Early Diversion Grants:**
  - Establishes or expands programs that divert adults with SMI or COD from CJ system to community-based services prior to arrest
  - ***Proposed $10 million increase for 2019***
- **Assisted Outpatient Treatment: civil commitment to outpatient treatment**
  - Implements and evaluates new AOT programs and identifies evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and CJ system interactions

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SAMHSA Justice Programs: Substance Use Disorders

- **Jail Diversion Program grants –**
  - Pre-booking diversion
  - Veterans programs
- **Drug Treatment Courts**
  - Adult drug courts, juvenile drug courts, family treatment drug courts
  - Drug court grantees may use up to 20 percent of their award for Medication Assisted Treatment (MAT)
  - From FY15-FY16, nearly 16,000 individuals were diverted into SAMHSA-supported drug court programs
- **Offender Reentry Program** – Expand access to substance use treatment services for individuals reintegrating into communities
  - Grantees may now begin process of linkage to services prior to release

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Solutions: SAMHSA Criminal Justice Programs and Activities

- **Training and Technical Assistance Programs**
  - **GAINS Center for Behavioral Health Transformation and Justice** – Provides webinars, TA events, and a wide variety of resources for providers and criminal justice practitioners
  - **Policy Academies**
  - **Technical Expert Panels**
    - Principles of community-based behavioral health services for criminal justice
    - Peer Roles in Criminal Justice Settings – draft core competencies for peer workers in criminal justice settings.
    - Web resources: *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide*

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Summary

- Does everyone with serious mental illness need to be committed to treatment?
- Should a person experiencing first episode psychosis be committed for treatment?
- We should reserve civil commitment for those disabled to the point of dangerousness
- Great majority of those with SMI will not need compulsory treatment
- Those with SMI of severity to present serious risk should have access to treatment and recovery services before legal issues arise
- Serious mental illness is not a crime. Let's get people the help they need to keep them out of the legal system.

Discussion

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