

Comments to the  
Mental Health and Wellness Commission

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Transfer Department of Corrections budget for mentally ill inmates to their PIHPs and bill PIHP for services

- Incentive for PIHP to avoid incarceration—How state hospitals were downsized
- Offenders get treatment and don't lose Medicaid and financial assistance

A shared, individual treatment plan is required for integration of health care

- Basis for collaboration and coordination
- Basis for determining billable services
- Basis for oversight for fraud and unnecessary procedures
- Basis for adoption of best practices

Integration should be focused on funding and collaboration, not consolidation of providers

- Patients must have choices of individual providers and treatments
- The single-site model of integration (the CMS model) is essentially a hospital —appropriate for a few but not for all
- New technology is available for “adaptive case management” to support coordination and accountability

Consolidation of community mental health operations

- One computer system (possibly multiple installations) for patient care systems
- Centralized responsibility and funding for research, training and development of best practices
- Consolidation of administrative functions—commodity services
- Consolidation of recipient rights and related functions (e.g., grievances, appeals, oversight) for consistency and objectivity—remove conflict of interest).

Mass murders (e.g., Navy Yard) by persons with a mental illness

- Many persons with mental illness are not capable of recognizing that they are ill (anosognosia)
- Most violent criminal behavior is not by persons with severe forms of mental illness
- We need early intervention and access criteria that address reality problems
- We need court ordered outpatient treatment (Kevins law) that is actually used

# Keeping Mentally Ill Persons out of the Criminal Justice System

Fred A. Cummins

We could realize a significant reduction in the prison population and increase federal funding by taking the steps described, below, to reduce the number of persons with mental illness involved with the criminal justice system. Studies have indicated that persons with mental illness are at least 16% and as much as 30% of the Michigan prison population.

Persons with mental illness deserve proper treatment for their mental illness. Prisons are the wrong place to deliver treatment. The prisoners with mental illness are vulnerable to abuse, they are likely to be disruptive, the prison guards are ill prepared to properly supervise them, they suffer unnecessarily in prison, and they will probably return to the community no better than when they were arrested.

Diverting offenders with mental illness to community care is not a new objective. It is even more important to prevent offenses in the first place. It is a matter of providing the proper incentives. Incentives were put in place to enable the closure of most of the state's psychiatric hospitals. The incentive is money. CMHSPs should pay for the incarceration and care of prisoners with mental illness just as they pay for persons in state psychiatric hospitals. The common thinking was that most of the persons in state hospitals could not be served in the community, but given the right incentives, CMHSPs developed programs to serve most of the persons with the most severe forms of mental illness. Unfortunately, many of these are now in our jails and prisons.

Currently, CMHSPs benefit from incarceration of their clients. These are the most difficult clients, and incarceration takes the clients off the CMHSP rolls.

To get this transformation started, funding for the cost of incarceration of each prisoner with mental illness should be transferred to their CMHSP based on their county of residence. Then the Department of Corrections should bill the CMHSPs for those prisoners. That's what was done with state hospitals. If CMHSPs can keep the savings, they will make it their job to keep people out of prison and facilitate early release.

This would not only reduce the prison population, but it would improve the treatment of persons with serious mental illness. It would reduce the risks of returning prisoners with mental illness to the community at the end of their sentence, and provide the opportunity for civil commitment of those who are not ready to live in the community. Prisoners with mental illness generally serve their full terms because they are judged poor candidates for parole. Consequently, they leave prison without oversight and parole restrictions.

If you ask Corrections or CMHSPs about this, they will say it won't work. Corrections won't want to give up control of their budget. CMHSPs will fear that their budget will be at risk if they can't keep people out of prison, and these probably are among the most difficult clients.

With appropriate treatment, it will be less expensive to treat people in the community rather than in prison. When clients are in the mental health system instead of prison, they will be eligible for Medicaid and Supplemental Security Income that they lose when incarcerated; some may be eligible for Medicare and SSDI. This will draw down more federal dollars to supplement the Michigan budget.

This is a win-win solution:

- Reduction of the cost of the corrections system,
- Increased federal dollars to help the budget,
- Improved treatment at lower cost for persons with mental illness,
- Reduction of criminal justice encounters by persons with mental illness in the community,
- Reduction of the trauma of mentally ill persons and their families,
- Relief for prisons from coping with these difficult inmates.