MICHIGAN'S MENTAL HEALTH CODE REFORMS*

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"*[W]hen mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system, with dire consequences to us all.*"[1]
— Chief Justice Judith S. Kaye

I. FROM JAILS TO ASYLUMS AND BACK AGAIN

In the early 1840s, Dorothea Dix launched a nationwide reform movement that established asylums across America for persons with mental illness.[2] People saw asylums as a humanitarian effort to end the practice of housing persons with mental illness in jails.[3] Over time, the number of persons in asylums (now called psychiatric hospitals) in the United States peaked in 1955 at about 560,000.[4]

The Community Mental Health Act of 1963 (the 1963 Act) represented the next major effort to address mental illness. The 1963 Act was designed to discourage the institutionalization of persons with mental illness and instead provide treatment in the community.[5] The 1963 Act contained two key promises.[6]

First, the federal government promised to pay the cost of treatment for indigent persons with mental illness, provided they were not institutionalized.[7] This created a financial incentive for states to close psychiatric hospitals and transfer the cost of care to the federal government.[8] The federal government kept this promise.[9]

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1. Matthew J. D'Emic, *The Promise of Mental Health Courts: Brooklyn Criminal Justice System Experiments with Treatment as an Alternative to Prison*, 22 CRIM. JUST. 24, 28 (2007) (quoting a November 25, 2002 press release from the New York State Office of Mental Health).

2. Eric Andrew Nelson, *Dorothea Dix's Liberation Movement and Why It Matters Today*, 17 AM. J. PSYCHIATRY RESIDENTS' J. 8, 8–9 (2021), http://psychiatryonline.org/doi/epdf/10.1176/appi.ajp-rj.2021.170203.

3. *See id.* (discussing the living conditions of mentally ill individuals in prisons and the concept of moral treatment in the United States).

4. MICH. MENTAL HEALTH COMM'N, *Part II: Appendices*, *in* FINAL REPORT, at 83 (2004), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder53/Folder1/Folder153/Final_MHC_Report_Part_2.pdf.

5. *See* MILTON L. MACK, JR., DECRIMINALIZATION OF MENTAL ILLNESS: FIXING A BROKEN SYSTEM, at 5 (2016–2017), https://www.ncsc.org/__data/assets/pdf_file/0018/23643/2016-2017-decriminalization-of-mental-illness-fixing-a-broken-system.pdf (discussing how the 1963 Act created a financial incentive and encouraged deinstitutionalization).

6. *See id.* at 4–5 (describing that the two broad promises of the 1963 Act were to provide funds for treatment and to facilitate the opening of community mental health centers).

7. MICH. MENTAL HEALTH COMM'N, *Part I: Final Report*, *in* FINAL REPORT, at 9 (2004), https://www.michigan.gov/mdhhs/-media/Project/Websites/mdhhs/Folder2/Folder62/Folder1/Folder162/Final_MHC_Report_Part_1.pdf.

8. *Id.*

9. *See* E. Fuller Torrey, *E. Fuller Torrey: Fifty Years of Failing America's Mentally Ill*, WALL ST. J. (Feb. 5, 2013, 7:04 PM), https://www.wsj.com/articles/SB10001424127887323539804578260023200841756 (discussing federal funding of community mental health centers).

Unfortunately, states like Michigan used most of their mental health appropriations initially used to support the public mental health system to match federal dollars instead, leaving little to serve those who did not meet Medicaid eligibility rules or were not in crisis.[10] This, in effect, converted state public mental health systems into Medicaid mental health systems, thereby limiting access to care for those who did not qualify for Medicaid or were not in crisis.[11]

Second, the federal government promised to provide a system of community mental health centers to replace psychiatric hospitals.[12] This promise was not kept.[13] However, Congress adopted the Bipartisan Safer Communities Act (BSCA) in June 2022, which may have the potential to finally uphold that promise. The BSCA provides a mechanism for nationwide deployment of federally funded community mental health centers known as Certified Community Behavioral Health Centers (CCBHCs) that provide services regardless of ability to pay.[14]

Following the adoption of the 1963 Act, states adopted mental health laws that dramatically increased the difficulty of involuntarily committing persons suffering from mental illness to a psychiatric hospital. The new laws provided strict due process protections and forbade hospitalization unless a person posed an immediate danger to self or others.[15] The only treatment those laws permitted was hospitalization.[16] At the same time, significant advancements were made in the diagnosis and treatment of mental illness.[17] The convergence of federal funding, state legislation, and treatment advancements helped facilitate the closure of most psychiatric hospitals in America.[18] Today, about 35,000 state psychiatric hospital beds remain in America.[19] According to the American Hospital Association, "[t]he number

10. *Part I: Final Report*, *supra* note 7, at 9–10 (discussing Michigan's response to the signing of the 1963 Act).

11. *Id.*

12. *Part II: Appendices*, *supra* note 4, at 84–85 (discussing how the 1963 Act funded community mental health centers).

13. MACK, *supra* note 5, at 4 (discussing why the development of community health centers failed).

14. Bipartisan Safer Communities Act of 2022, Pub. L. No. 117–159, § 11001, 136 Stat. 1313. CCBHCs are designed to provide crisis services regardless of insurance status or ability to pay. *Certified Community Behavioral Health Clinics (CCBHCs)*, SAMHSA, https://www.samhsa.gov/certified-community-behavioral-health-clinics (Mar. 24, 2022).

15. *See* Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 33 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf (discussing additional criteria for civil commitments).

16. *See* MACK, *supra* note 5, at 5 (discussing the requirements for court-ordered hospitalization).

17. *See Part I: Final Report*, *supra* note 7, at 9, 12 (discussing advancements in mental illness treatment).

18. *Id.* at 9.

19. TREATMENT ADVOC. CTR., HOW MANY PSYCHIATRIC BEDS DOES AMERICA NEED? (2016), https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how-many-psychiatric-beds-does-america-need.pdf.

of state-funded psychiatric beds per capita has declined by 97% between 1955 and 2016."[20]

Many of those who were institutionalized successfully transitioned into the community.[21] However, because the promised system of federally funded outpatient care did not materialize, a significant number of people went untreated, leading to poor health, poverty, homelessness, and incarceration.[22] For far too many, jails and prisons once again became the primary institutions for persons with mental illness, much like early in the nineteenth century.[23]

It is estimated that 356,000 persons with serious mental illness are in state prisons, and over the course of a year, approximately two million persons with serious mental illness will spend time in our nation's county and local jails.[24] According to the Michigan Department of Corrections, approximately 34% of Michigan's prisoners have a mental illness.[25]

II. DIVERSION AND THE SEQUENTIAL INTERCEPT MODEL: ATTEMPTS TO STOP THE REVOLVING DOOR

"*[O]ur criminal justice system is the repository of many failed public policies, and there really is no greater failed public policy than our treatment towards people with mental illnesses.*"[26]

The rapid increase of persons with mental illness ensnared in the criminal justice system led to the development of diversion programs and the Sequential Intercept Model (SIM).[27]

The SIM was developed to map the points (intercepts 0–6) in the criminal justice system at which providing mental health, substance use disorder, and co-occurring services could help prevent further engagement

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20. Memorandum from the Am. Hosp. Ass'n on America's Mental Health Crisis to the Comm. on Ways & Means of the U.S. House of Representatives, at 2 (Feb. 22, 2022), https://www.aha.org/system/files/media/file/2022/02/aha-house-statement-ways-and-means-committee-americas-mental-health-crisis-statement-2-2-22.pdf.

21. *Part II: Appendices*, *supra* note 4, at 85.

22. MACK, *supra* note 5, at 4–5.

23. *Id.* at 2.

24. TREATMENT ADVOC. CTR., HOW MANY INDIVIDUALS WITH SERIOUS MENTAL ILLNESS ARE IN JAILS AND PRISONS? (2014), https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf; Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 764 (2009), https://ps.psychiatryonline.org/doi/epdf/10.1176/ps.2009.60.6.761.

25. E-mail from Marti Kay Sherry, Health Servs. Adm'r, Michigan Dep't of Corr. Bureau of Healthcare Services, to Author (Nov. 1, 2022, 11:36 AM) (on file with Author).

26. TEX. TECH L. REV., *2022 Texas Tech Mental Health Law Symposium*, TEX. TECH UNIV. SCH. OF L., at 2:58:06–2:58:17 (Apr. 8, 2022), https://mediaservices.law.ttu.edu/Panopto/Pages/Viewer.aspx?id=bf9c2caa-79b4-4bbd-93b7-ae740004343c.

27. POL'Y RSCH. ASSOCS., THE SEQUENTIAL INTERCEPT MODEL, https://www.prainc.com/wp-content/uploads/2018/06/SIM-Brochure-2018-Web.pdf (last visited Sept. 15, 2022).

with the criminal justice system.[28] Texas Supreme Court Justice Jane Bland has explained that the SIM tries to unite these fragments.[29] Intercept 0 represents the earliest opportunity for intervention, preferably before a person engages the criminal justice system.[30]

Initially, intercept 0 was not part of the SIM but was added to recognize the importance of intervening before engaging the criminal justice system.[31] The current version of intercept 0 calls for crisis lines, mobile crisis units (with or without law enforcement), and warm handoffs from emergency departments to community treatment providers.[32]

However, as this Article demonstrates, intercept 0, as currently designed, is insufficient to significantly reduce the cycle of incarceration, hospitalization, and emergency department visits. Intercept 0 could be far more impactful by improving the civil justice system to promote early intervention and the use of court-ordered outpatient treatment.

Diversion efforts included the creation of problem-solving courts.[33] These programs, while helpful, cannot be scaled up to significantly alleviate the problem. For example, Michigan has over 200 problem-solving courts that served about 7,000 individuals in 2021.[34] However, about 3,800 defendants were rejected due to legal criteria and other barriers.[35]

In contrast, over 165,000 individuals visited Michigan's emergency departments for psychiatric care in 2020,[36] which led to the filing of 18,000 petitions for involuntary mental health treatment with Michigan's probate courts.[37] However, hospitals discharged most individuals who were petitioned prior to the hearing with no follow-up care in the community.[38] This resulted in repeated short-term emergency department visits and brief hospital admissions without follow-up care in the community, leading to repeat emergency department visits, hospitalizations, and encounters with law enforcement. This is the classic "revolving door syndrome."[39]

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28. *Id.*

29. E-mail from Justice Jane Bland, Tex. Sup. Ct., to Author (Aug. 10, 2022, 12:09 PM ET) (on file with Author).

30. THE SEQUENTIAL INTERCEPT MODEL, *supra* note 27.

31. *Id.*

32. *Id.*

33. *See* MICH. SUP. CT., FY 2021 PROBLEM-SOLVING COURTS ANNUAL REPORT, at 7 (2022), https://www.courts.michigan.gov/496434/siteassets/reports/psc/pscannualreportfy2021.pdf.

34. *See id.* at 4, 12, 31, 41.

35. *Id.*

36. Mich. Suicide Prevention Comm'n, *Building a Crisis Services System for All Michiganders: 988's & MiCAL's Role*, MICHIGAN.GOV (Nov. 19, 2021), https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder50/Folder13/MI_Suicide_Prev_Commission_111721.pdf.

37. MICH. SUP. CT., 2020 COURT CASELOAD REPORT: STATEWIDE CIRCUIT COURT SUMMARY (2020) [hereinafter 2020 COURT CASELOAD REPORT], https://www.courts.michigan.gov/4a5431/siteassets/reports/statistics/caseload/2020/statewide.pdf.

38. *See id.* (demonstrating the number of cases for psychiatric patients in Michigan during 2020).

39. Nat'l Inst. for Occupational Safety & Health, *"Revolving Door" Syndrome*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 7, 2020), https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit3_11.

In addition, growing evidence shows that delay in treatment is harmful to individuals with serious mental illness.[40] One study found that "patients . . . [with] early intervention strateg[ies] had 3.2 fewer hospitalizations and 2.7 more years of employment throughout their remaining life expectancy."[41]

Providing early, comprehensive, and coordinated care in the community for persons who do not understand their need for treatment creates significant opportunities for recovery and early avoidance of the criminal justice system.[42]

The civil justice system and community mental health agencies should work together to ensure timely and appropriate mental health treatment for those who need it when they need it. In sum, treatment for those who require treatment but do not understand their need for it should be managed by the civil justice system and should not wait for the criminal justice system.

In 2004, Michigan took a step in the right direction by adopting a law permitting court-ordered Assisted Outpatient Treatment (AOT).[43] The law, known as Kevin's Law, was in response to the murder of Kevin Heisinger by a young man with untreated schizophrenia.[44] However, the law was rarely used in the following twenty years because of barriers to its use.[45] For example, to invoke the law, it was required that individuals have two prior hospitalizations or incarcerations, along with proof that they were noncompliant with an existing treatment plan.[46] If there was no prior treatment plan, a court could not order treatment.[47] If there was a treatment plan, the Health Insurance Portability and Accountability Act (HIPPA) made it difficult to secure a copy of the plan.[48] The following Part describes how Michigan revised its Mental Health Code (the Code) to make the use of AOT easier and more effective.

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40. Catherine G. McLaughlin, *Delays in Treatment for Mental Disorders and Health Insurance Coverage*, 39 HEALTH SERVS. RSCH. 221, 221 (2004).

41. Saadia Sediqzadah et al., *Cost-Effectiveness of Early Intervention in Psychosis: A Modeling Study*, 73 PSYCHIATRIC SERVS. 970, 970 (2022), https://ps.psychiatryonline.org/toc/ps/73/9.

42. This is also a recommendation of the National Judicial Task Force to Examine State Courts' Response to Mental Illness. *See* NAT'L JUD. TASK FORCE TO EXAMINE STATE CTS.' RESPONSE TO MENTAL ILLNESS, STATE COURTS LEADING CHANGE, REPORT AND RECOMMENDATIONS (Oct. 2022), https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf.

43. Ted Roelefs, *Revision to 'Kevin's Law' Means Quicker Treatment for the Mentally Ill*, BRIDGE MICH. (Jan. 12, 2017), https://www.bridgemi.com/children-families/revision-kevins-law-means-quicker-treatment-mentally-ill.

44. *Id.*

45. *See id.* In 2016, while there were over 18,000 petitions for mental health treatment, courts received only seventy-three petitions for AOT. MICH. SUP. CT., 2016 COURT CASELOAD REPORT: STATEWIDE CIRCUIT COURT SUMMARY (2016), https://www.courts.michigan.gov/49dfd5/siteassets/reports/statistics/caseload/2016/statewide.pdf.

46. 2004 Mich. Pub. Acts 496, 498.

47. *See id.* at 496.

48. *See* INST. OF MED. OF THE NAT'L ACADS., IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS, at 406 (2006), https://www.ncbi.nlm.nih.gov/books/NBK19830/pdf/Bookshelf_NBK19830.pdf.

III. ASSISTED OUTPATIENT TREATMENT LAWS IN MICHIGAN

Over the last two decades, many states have formed commissions to study the problems facing mental health systems. In 2004, Michigan's Governor, Jennifer Granholm, created the Michigan Mental Health Commission.[49] In the commission's report, it recommended modifying the Code to permit earlier intervention—before a person is in crisis.[50] The commission found that intervention often comes too late to prevent criminal justice involvement, homelessness, and poverty.[51] The commission described the Code as "an inpatient model in an outpatient world"[52] because the vast majority of mental health treatment was being delivered in the community.[53] It also urged focusing on prevention and early intervention beginning in the primary care setting.[54] The commission urged modifying the Code to "simplify the assessment of persons who may need mental health services and assure care more quickly."[55]

The commission stated that "[t]reatment advances have significantly increased the possibility that adults with serious mental illness will recover and children with severe emotional disturbance will develop resilience."[56] Again, the commission urged a public education campaign to inform the public that "mental illness and emotional disturbance are treatable, recovery is possible, and people with mental illness and emotional disturbance [can] lead productive lives."[57] With this understanding, there would be more public support for earlier intervention to avoid crisis.

It took time and persistence, but in 2016 and 2018, Michigan finally amended its Code, including Kevin's Law, to permit earlier intervention and provide a process to order AOT.[58] In this way, the legislature was finally converting the Code to an outpatient model that conformed to the outpatient world of mental health treatment.[59]

The amendments to the Code removed barriers preventing the use of AOT, permitted earlier intervention, and provided a process for families to

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49. *Part I: Final Report*, *supra* note 7, at 1.

50. *Id.* at 30.

51. *Id.* at 14.

52. Valerie A. Canady, *Michigan's AOT Bill Aims to Close Gaps, Provide Early Intervention Services*, MENTAL HEALTH WKLY., Sept. 28, 2015, at 1, 2.

53. In 2019, state mental health agencies served 7,818,694 persons. NAT'L ASSOC. OF STATE MENTAL HEALTH PROGRAM DIR. RSCH. INST., FY 2019 STATE MENTAL HEALTH AGENCY REVENUES AND EXPENDITURES: NRI'S 2020-2021 STATE MH PROFILE HIGHLIGHTS, at 1 (2022), https://www.nri-inc.org/media/rmrd2s5e/nri-2020-profiles-trends-in-smha-expenditures-and-funding-for-mental-health-services-fy-2001-to-fy-2019.pdf. The agencies served 135,502 individuals in state psychiatric hospitals. *Id.*

54. *Part I: Final Report*, *supra* note 7, at 30.

55. *Id.*

56. *Id.* at 12.

57. *Id.* at 27–28.

58. *See* 2016 Mich. Pub. Acts 320; 2018 Mich. Pub. Acts 590–596.

59. *See* 2016 Mich. Pub. Acts 320; 2018 Mich. Pub. Acts 590–596.

obtain outpatient treatment without hospitalization.[60] However, while these changes in the law lowered the barriers to timely treatment, implementation remains a challenge.[61] Mental health care providers have been slow to recognize the benefits of AOT and modify their practices to utilize it as intended.[62]

Michigan's mental health system, like many states', is fragmented, and collaboration among stakeholders is challenging.[63] However, in some communities, stakeholders have begun working together to implement the new laws and have been rewarded with positive results.[64] These communities have discovered that collaboration across stakeholders and fidelity to the law are critical to successfully implementing the new process and the use of court-ordered AOT.[65] Communities have also seen improvements in treatment engagement and recovery for those suffering from serious mental illness.[66] These communities have also seen reduced hospitalization and engagement with the criminal justice system.[67]

IV. MICHIGAN'S NEW STANDARD FOR INTERVENTION

Michigan's former code, like most states', required immediate danger to self or others, such as threatening suicide or homicide, before a court could order treatment.[68] Michigan's new standard focuses on the risk of harm due to the individual's lack of insight into their need for and refusal to accept treatment.[69] The immediacy of the risk of harm governs whether hospitalization or AOT is the least restrictive and most appropriate form of treatment.[70] The Code uses the same standard for ordering treatment whether it is inpatient, outpatient, or a combination of the two.[71]

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60. *See* 2016 Mich. Pub. Acts 320; 2018 Mich. Pub. Acts 590–596.

61. *See Assisted Outpatient Treatment Toolkit Bridges the Gap of Mental Health Treatment Law and Implementation*, WAYNE STATE UNIV. (July 1, 2022) [hereinafter *Assisted Outpatient Treatment Toolkit Bridges the Gap*], https://behaviorhealthjustice.wayne.edu/news/assisted-outpatient-treatment-toolkit-bridges-the-gap-of-mental-health-treatment-law-and-implementation-48866.

62. *See id.*

63. *See Part I: Final Report*, *supra* note 7, at 25 (illustrating the design of Michigan's mental health system).

64. *See* Mich. Mental Health Diversion Council, *Assisted Outpatient Treatment: The Court's Role in Providing Practical Mental Health Treatment*, YOUTUBE (June 30, 2022), https://www.youtube.com/watch?v=7k3pkcnsTEQ.

65. *See id.*

66. *See id.*

67. *See id.* (emphasizing the state decrease in hospital recidivism and a generally positive trend in incarcerations resulting from the implementation of the Genesee Health System AOT program in 2020).

68. *See* 2004 Mich. Pub. Acts 496.

69. MICH. COMP. LAWS § 330.1401(1)(c) (2022).

70. Telephone Interview with Jennifer Kimmel, Supervisor of the Assisted Outpatient Treatment Program, Genesee Health Sys. (Mar. 29, 2021).

71. *See* MICH. COMP. LAWS §§ 330.1401(1)(a)–(c), .1472a(1)(a)–(c) (2022).

Regardless of the relief sought in a petition, the first question the court addresses is whether the individual is a person requiring mental health treatment.[72] It makes no difference whether a petitioner seeks hospitalization or outpatient treatment.[73] The legislative revisions dramatically changed the standard for ordering treatment to permit earlier intervention and not require waiting for a crisis.[74]

Under Michigan's new Code, an individual is a "person requiring treatment" if either (a), (b), or (c) below is established:

> (a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.
> (b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of [their] basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.
> (c) An individual who has mental illness, whose judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused [them] to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.[75]

This change in the law shifted the court's focus from a person's *conduct* to a person's *capacity* to understand their need for treatment.[76] Now, there is no requirement of danger to self or others, immediate risk of harm, or, under Subsection (c), that harm will occur in the near future.[77] The statute now recognizes that untreated mental illness may itself create a risk of harm due to relapse or harmful deterioration of a person's condition because of the individual's lack of understanding of their need for treatment.[78]

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72. *See id.* §§ 330.1468, .1472a(1)(a)–(c).
73. *See id.* § 330.1468(2).
74. *See id.* § 330.1401(1)(a)–(c).
75. *Id.*
76. *See id.*
77. *Id.*
78. *Id.* Dr. Oris Newman of the Center for Forensic Psychiatry in Michigan explained that each psychotic episode damages the brain, and recurring episodes make it more difficult to treat the illness. E-mail from Oris Newman, Staff Psychiatrist, Ctr. for Forensic Psychiatry, to Author (Sept. 16, 2022, 9:45 PM ET) (on file with Author).

Other states are also modifying their mental health laws to permit earlier intervention without waiting until someone's condition makes them dangerous to themselves or others or places them at immediate risk of harm.[79] For example, Louisiana recently amended its mental health law, effective August 1, 2022, to permit ordering treatment for a person unable to provide for their own medical care because of serious mental illness or substance use disorders, including incapacity by alcohol, that cause the person to be unable to protect himself from significant psychiatric deterioration.[80] Psychiatric deterioration is defined as "a decline in mental functioning, which diminishes the person's capacity to reason, exercise judgment, or control [their] behavior."[81]

Michigan's new law, which permits court-ordered AOT using the same criteria for ordering hospitalization, removed a barrier to timely, appropriate treatment.[82] Previously, Michigan—like many states—only permitted court-ordered outpatient treatment under limited circumstances, such as requiring two prior hospitalizations or incarcerations due to mental illness.[83] In other words, courts could not order AOT upon the first or second time someone was hospitalized or incarcerated due to mental illness, even though AOT is less restrictive than hospitalization and incarceration.[84] The Equitas Project, in its August 2022 report, recommended one process for ordering treatment for mental illness with a presumption that AOT is the least restrictive alternative.[85]

The Michigan Court of Appeals recently had the opportunity to apply the new standards for ordering treatment.[86] In *In re Tchakarova*, the court held that the respondent's delusions relating to stalking professors impaired her judgment and created a substantial risk of harm to herself or others under Subsection (c) of the Code.[87] The doctor testified, and the court of appeals agreed, that the respondent's judgment was impaired both in relation to her inability to acknowledge her need for treatment and the risk of harm to others.[88] The court also found that her tickets for reckless driving and speeding were "acts" within the meaning of Subsection (a), supporting a reasonable expectation of intentional or unintentional harm, although those tickets were not recent.[89]

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79. LA. STAT. ANN. § 28 (2011).
80. *Id.* § 28:21.1.
81. *Id.* § 28:2(40); 2022 La. Acts 382.
82. MICH. COMP. LAWS § 330.1468 (2022).
83. 2004 Mich. Pub. Acts 469–499.
84. *Id.*
85. MENTAL HEALTH COLO., THE EQUITAS PROJECT, at 10–11 (Aug. 2022), https://www.mentalhealthcolorado.org/wp-content/uploads/2022/08/Model-Legal-Processes-to-Support-Clinical-Intervention-for-Persons-with-Severe-Mental-Illness-FINAL-8.2022.pdf.
86. *In re* Tchakarova, 936 N.W.2d 863, 868 (Mich. Ct. App. 2019).
87. *Id.* at 870.
88. *Id.* at 865.
89. *Id.* at 866.

Similarly, in *In re Heidarisafa*,[90] an unpublished opinion,[91] the Michigan Court of Appeals held that an act that occurred two years prior to the petition was not too remote to support a finding that the person needed treatment under Subsection (a).[92] The court observed that the statutory language focuses on whether the acts, regardless of when they occurred, are substantially supportive of the expectation that the individual can be reasonably expected to injure themselves or others within the near future.[93]

In *In re Spaulding*,[94] an unpublished opinion, the Michigan Court of Appeals affirmed an order for treatment even though the doctor "testified that he did not believe the respondent was at risk of harming himself or others at the time of the hearing."[95] However, the doctor testified that the respondent lacked insight into his need for treatment, and if he were to refuse medication, "in three to six months[,] he would likely lose touch with reality and experience delusions."[96] The doctor testified that, if left untreated, the respondent was at risk of decompensation, creating a "risk of dementia, drug abuse, and suicide."[97]

As the Michigan Mental Health Commission urged in 2004, the Code is finally designed to permit intervention without waiting for a crisis.[98] The test is not about whether someone requires hospitalization.[99] The test is whether someone requires treatment.[100] Whether that treatment is required in the hospital or can be provided in the community is a clinical decision.[101]

The new Code creates two pathways to secure AOT. The new pathway authorizes petitions for AOT only, bypassing hospitals.[102] The traditional model still begins in the hospital but provides for AOT at discharge.[103] The same form is used for both pathways.[104]

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90. *In re* Heidarisafa, No. 353582, 2021 WL 941071, at *2 (Mich. Ct. App. Mar. 11, 2021).

91. "An unpublished opinion is not precedentially binding under the rule of stare decisis . . . [and] should not be cited . . . [if] there is published authority." MICH. COMP. LAWS § 7.215(C)(1). Unpublished opinions may be cited. *See id.*

92. *Heidarisafa*, 2021 WL 941071, at *2.

93. Similarly, in *In re* Scoby, No. 359756, 2022 WL 2288385, at *2 (Mich. Ct. App. June 23, 2022), an unpublished opinion, the Michigan Court of Appeals observed that there was no language in the statute prohibiting probate courts from considering past actions and convictions that occurred before the current hospitalization.

94. *In re* Spaulding, No. 354408, 2021 WL 941529, at *2–3 (Mich. Ct. App. Mar. 11, 2021).

95. *Id.* at *2.

96. *Id.*

97. *Id.* at *3.

98. *See Part I: Final Report*, *supra* note 7, at 30–32.

99. *See id.* (arguing that the evaluation should be focused on the need for health services).

100. MICH. COMP. LAWS §§ 330.1401, .1468(2) (2022).

101. *See id.* § 330.1474(1).

102. *See id.* § 330.1434.

103. *Id.*

104. *See* Memorandum from Rebecca A. Schnelz, Forms & Res. Analyst, on Notice of Revisions to PCM 201 (Mar. 28, 2019), https://www.courts.michigan.gov/49601b/siteassets/forms/scao-approved/recent-revisions/recentrevisions-sheryl-review/pcm_3-19_notice_of_revisions.pdf.

V. PETITIONS THAT ONLY ASK FOR AOT

Any interested person may file a petition directly with the probate court asking the court to order that an individual receive AOT.[105] Hospitalization is not required when filing the petition nor while the petition is pending.[106] Additionally, there is no requirement to attach medical documentation to the filing because the person is not involuntarily hospitalized pending the hearing.[107] The hearing date is scheduled twenty-eight days after filing.[108] This enables the petitioner to secure an examination, if necessary, before the hearing.[109] While the petition is pending, the respondent's liberty interest is not impaired.[110] However, if the respondent refuses examination by a psychiatrist prior to the hearing, the petitioner can request an order for examination.[111] The court can then order a peace officer to transport the respondent to a crisis center, provided that the petitioner has made reasonable efforts to secure an examination.[112]

Examinations required for petitions only asking for AOT must "be arranged by the court and the local community mental health services program or other entity as designated by the [Michigan Department of Health and Human Services]."[113]

> [At] the hearing, an individual may not be found to require treatment unless a psychiatrist who has personally examined that individual testifies. A psychiatrist's testimony is not necessary if a psychiatrist signs the petition . . . [and a] physician or licensed psychologist who has personally examined that individual [testifies] . . . . The requirement for testimony may be waived by the subject of the petition.[114]

However, if clinical testimony is waived, "a clinical certificate completed by a physician, licensed psychologist, or psychiatrist must [still] be presented to the court before or at the initial hearing."[115]

The requirement that a psychiatrist testify in court remains a barrier to more widespread use of this process. The Code does not require a psychiatrist to testify at a hearing that seeks hospitalization or even a combined order of hospitalization and AOT.[116] Frankly, any qualified mental health professional

105. MICH. COMP. LAWS § 330.1434(1), (7) (2022).
106. *Id.* § 330.1437.
107. *Id.* § 330.1435(c).
108. *Id.* § 330.1452(2).
109. *See id.* § 330.1461(2).
110. *See id.* (discussing how a petitioner's liberty is not diminished while a petition is pending).
111. *Id.* § 330.1436(3).
112. *Id.*
113. *Id.* § 330.1461(3).
114. *Id.* § 330.1461(2).
115. *Id.*
116. *See id.* § 330.1464(a).

should be able to testify as to the need for treatment.[117] A psychiatrist will supervise the treatment and can terminate the treatment if clinically appropriate.[118] Considering the shortage of psychiatrists and other mental health professionals, permitting the use of a qualified mental health professional to testify as to the need for treatment is a much wiser use of scarce resources, particularly in rural areas, and promotes the use of the AOT-only process, reducing hospital and emergency department visits.[119]

At the hearing, if the court finds by clear and convincing evidence that the respondent is a person requiring treatment,[120] the court can order hospitalization, AOT, or a combined order of both.[121] It is very rare for a court to order anything other than AOT for a petition only seeking AOT.[122]

The statute lists a variety of services a court can order, including case management, medication (including injectables), blood or urinalysis tests, individual or group therapy, day or partial day programs, educational or vocational training, supervised living, assertive community treatment team services, substance use disorder treatment and testing, or any other service that would help prevent relapse or deterioration resulting in hospitalization.[123]

The court's order constitutes authority to provide services, as evidenced by the fact that the statute provides that a psychiatrist must supervise the preparation and implementation of the AOT plan within thirty days of the court's order and then forward it to the probate court for filing.[124] While the court may order various services, the psychiatrist has the final say on what services are actually provided.[125] The court will rely on the plan filed with the court in the event of a claim that the individual is noncompliant with the treatment plan.[126] Perhaps the best way to harmonize these provisions is this: if the psychiatrist orders treatment not provided for in the court's order, the court will not enforce it.[127] In that event, one can ask the court to modify the plan to incorporate the psychiatrist's recommendation.[128] On the other hand,

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117. *See* E-mail from Marti Kay Sherry, *supra* note 25.

118. MICH. COMP. LAWS § 330.1477(a) (2022).

119. NAT'L JUD. TASK FORCE TO EXAMINE STATE CTS.' RESPONSE TO MENTAL ILLNESS, IMPROVED CIVIL COURT-ORDERED TREATMENT RESPONSES, at 2 (July 2022) https://www.ncsc.org/__data/assets/pdf_file/0021/79311/Improved-Civil-Court-Ordered-Treatment-Responses.pdf.

120. MICH. COMP. LAWS § 330.1465 (2022).

121. *Id.* § 330.1468(2).

122. *See* IMPROVED CIVIL COURT-ORDERED TREATMENT RESPONSES, *supra* note 119, at 1 (explaining that courts should order AOT unless it would be unsafe or ineffective).

123. MICH. COMP. LAWS § 330.1468(2)(d) (2022).

124. *Id.* § 330.1468(3).

125. *See id.* (explaining that a psychiatrist will supervise and implement the plan).

126. *See id.* § 330.1475(2) (noting the court will make a decision based on the record and other available information).

127. *See id.* § 330.1468(6) (explaining that if an order conflicts with an existing plan, it may be reviewed for possible adjustment).

128. *Id.* § 330.1475(2)(b).

the psychiatrist determines what services to provide and how long the AOT will continue.[129]

> If it comes to the attention of the court that an individual . . . is not complying with the order, the court may require[,] . . . without a hearing[,] . . . [t]hat the individual be taken to a preadmission screening unit . . . [or] hospitalized for a period of not more than 10 days.[130]

However, if a bed is not available or the person does not meet the criteria for hospitalization, that option is not available.[131] Courts are finding it more effective to schedule a video conference with the individual and encourage treatment engagement, relying on the "black robe effect."[132]

Recently, mediation—which the Mental Health Commission recommended[133]—was added as an alternative to court hearings to promote treatment engagement and ownership of the treatment plan.[134]

In 2020, the legislature adopted Public Act 55 to provide for the use of mediation in mental health proceedings.[135] Previously, mediation was not a practical option because courts were required to hold hearings on petitions within seven days of filing.[136] Petitions only seeking AOT are set for hearing in twenty-eight days, providing plenty of time to schedule mediation.[137] No liberty interest is at stake prior to the hearing because the individual is not hospitalized.[138] This creates an opportunity to mediate treatment issues before the hearing date.[139] If progress is made with mediation, the court can adjourn the hearing date because the individual is not hospitalized.[140]

Following the adoption of Public Act 55, the Michigan Department of Health and Human Services (MDHHS) issued a grant to the Michigan Community Mediation Association to make mediation services available through Michigan's seventeen community dispute resolution centers that provide mediation services across the state.[141] The program is currently in the

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129. *Id.* § 330.1474(1).

130. *Id.* § 330.1475(4)(a)–(b).

131. *See id.* (noting that the court may consider alternatives if the treatment is not sufficient or appropriate).

132. *See* Mark R. Munetz, *Black Robe/White Coat: Mental Health Providers Must Reclaim the Role of Caring Clinician*, 71 PSYCHIATRIC SERVS. 403, 403 (2020), https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201900366.

133. *Part I: Final Report*, *supra* note 7, at 31.

134. MICH. COMP. LAWS § 330.1206a (2022).

135. 2020 Mich. Pub. Acts 3.

136. 1995 Mich. Pub. Acts 290 (codified at MICH. COMP. LAWS § 330.1206a (2022)).

137. *Mental Health*, TRIAL CT. WASHTENAW CNTY. MICH., https://www.washtenaw.org/1236/mental-health (last visited Sept. 15, 2022).

138. *See id.* (stating that the delayed hearing is available for non-inpatient subjects at a psychiatric hospital).

139. *See id.*

140. *See id.* (discussing procedures for petitions and petition dismissal).

141. CMTY. DISPUTE RESOL. PROGRAM, ANNUAL REPORT 2021, at 2 (2021), https://www.courts.mic

implementation phase and is just beginning.[142] As of July 1, 2022, three of five cases were successfully mediated, and one reached a partial agreement.[143] This process will also be accessible to treatment providers for individuals who are becoming noncompliant. Rather than proceed immediately to court, providers and individuals can start with mediation.[144] Mediation is generally a better process than trial.[145] "Mutual collaboration fosters greater patient satisfaction, reduces the risks of nonadherence, and improves patients' healthcare outcomes."[146] A successful mediation is far more likely to lead to long-term treatment engagement and adherence than a court order.[147]

VI. PETITIONS FOR HOSPITALIZATION OR COMBINED ORDERS OF HOSPITALIZATION AND AOT

Anyone over the age of eighteen may file a petition asserting "that an individual is a person requiring treatment."[148] Unless the petition only seeks AOT, the petition may not be set for hearing until the court receives "a clinical certificate executed by a physician or licensed psychologist[] and a clinical certificate executed by a psychiatrist."[149] This process requires hospital admission to obtain clinical certificates and secure a hearing date.[150]

People arrive at the hospital in several ways. Law enforcement or a family member may bring an individual to the emergency department.[151] Often the individual shows up at the emergency department looking for help.[152] Although law enforcement and family members may sign a petition for treatment, the hospital is not required to file the petition with the court.[153]

Once the clinical certificates are filed with the court and the petition is scheduled for hearing, the hospital is required to schedule a deferment

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higan.gov/49fd0a/siteassets/reports/odr/cdrp-annual-report-2021.pdf.

142. *See id.* (noting that more dispute resolution types are coming soon).

143. *See, e.g.*, *id.* (reporting that in 2021, 69% of cases in Michigan successfully settled through mediation and other dispute resolution services).

144. MICH. COMP. LAWS § 330.1475 (2022).

145. *See* Nancy Thoennes, *What We Know Now: Findings from Dependency Mediation Research*, 47 FAM. CT. REV. 21, 23–36 (2008); Jessica Pearson & Nancy Thoennes, *The Benefits Outweigh the Costs*, 4 FAM. ADVOC. 26, 28–32 (1982).

146. Leslie R. Martin et al., *The Challenge of Patient Adherence*, 1 THERAPEUTICS & CLINICAL RISK MGMT. 189, 189 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1661624/pdf/tcrm0103-189.pdf.

147. *See* Thoennes, *supra* note 145, at 23–36; Pearson & Thoennes, *supra* note 145, at 28–32.

148. MICH. COMP. LAWS § 330.1434(1) (2022).

149. *Id.* § 330.1452(1)(a).

150. *Id.*

151. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE, at 12 (2019) [hereinafter CIVIL COMMITMENT], https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

152. *See id.* at 13.

153. MICH. COMP. LAWS § 330.1434 (2022).

conference with the individual, the individual's attorney, a representative of the hospital, and a representative from the community mental health agency.[154] If the individual agrees to treatment, the hearing is adjourned, but in the event of noncompliance with treatment over the next 180 days, one can file a demand for a hearing to seek a court order for treatment.[155]

Prior to the hearing, if the hospital determines the person is suitable for voluntary hospitalization, it may offer the individual an opportunity to voluntarily sign in.[156] The hospital can discharge the individual if it determines that hospitalization is no longer required.[157] Although the hearing is scheduled seven days after the petition is filed, most cases do not make it to court.[158] Instead, patients are either discharged or they sign a voluntary admission document or deferral.

For those cases that are heard, the court can enter a combined order for up to 180 days of AOT, including up to sixty days of hospitalization.[159] The court order can also provide that if the individual refuses to comply with a psychiatrist's order for hospitalization, a peace officer shall take the individual into custody and transport them to the hospital designated by the psychiatrist.[160]

VII. BUT IT STILL TAKES A COMMUNITY

Revising mental health laws to align with science is an essential step in fixing the system.[161] However, putting those laws to work is challenging because the delivery system is fragmented, and there is little collaboration.[162] The barriers to early intervention have been in place for decades.[163] Changing the law is not enough; it is necessary to change the culture. For the last fifty years, the test for ordering involuntary treatment has been whether the individual poses a "danger[] to self or others."[164] Hospitals have been the primary institutions used to respond to crisis.[165] It will take time to change the focus of addressing mental health crises from hospital-based to community-based. It will require collaboration between stakeholders that

154. *Id.* § 330.1455(5).
155. *Id.* § 330.1455(9).
156. *Id.* § 330.1406.
157. *Id.* § 330.1476(1).
158. *Id.* § 330.1452.
159. *Id.* § 330.1472(a).
160. *Id.* § 330.1469(a)(2).
161. Michigan's mental health legal framework received an "A" rating from the Treatment Advocacy Center in 2020. LISA DAILEY ET AL., GRADING THE STATES: AN ANALYSIS OF U.S. PSYCHIATRIC TREATMENT LAWS, at 5 (2020), https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf.
162. *Part I: Final Report*, *supra* note 7, at 10.
163. *Id.* at 9.
164. CIVIL COMMITMENT, *supra* note 151, at 4.
165. *Id.* at 6.

have not traditionally worked together to achieve the full potential of these reforms.

AOT is effective in securing treatment adherence and promoting recovery.[166] AOT also reduces hospitalization, homelessness, arrest, and incarceration.[167] AOT is a low-cost alternative to emergency departments and hospitalization and is more effective at securing long-term recovery.[168]

It is estimated that 50% of the population across America suffering from serious mental illness does not have access to mental health treatment.[169] From 2006 to 2014, nationwide emergency–department–patient volume increased 15%, but psychiatric volume increased 44%.[170] The size of the challenge and opportunity to improve the lives of those suffering from serious mental illness is enormous. For example, for three consecutive years, MDHHS reported that psychiatric care was the number-one reason for emergency room visits.[171] MDHHS reports that there were 165,712 visits for psychiatric care in emergency rooms in Michigan's acute-care hospitals in 2020 and over 200,000 in the two prior years.[172] In 2020, 18,000 petitions for mental health treatment were filed in Michigan's probate courts, yet only 6,537 resulted in court-ordered treatment.[173] It is unknown whether the other 159,175 emergency room visits resulted in connection to outpatient treatment.[174] But strong evidence shows that many of these visitors were not

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166. *Id.* at 20.

167. *Id.*

168. TREATMENT ADVOC. CTR., ASSISTED OUTPATIENT TREATMENT: IMPROVING OUTCOMES AND SAVING MONEY (June 2021), https://www.treatmentadvocacycenter.org/storage/documents/tac-aot-summary-pdf.pdf.

169. *Mental Illness*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Sept. 15, 2022).

170. Wayne State Univ. Ctr. for Behav. Health & Just., Hospital Collaboration Meeting with the Mental Health Initiative (Feb. 11, 2021).

171. MICH. DEP'T OF HEALTH & HUMAN SERVS., 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY: EMERGENCY SERVICES FOR ACUTE CARE HOSPITAL BY TYPE OF SERVICE REPORT 112, at 5 (2022) [hereinafter 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY], https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Health-Care-Providers/Certificate-of-Need/CON-Eval/Survey-Reports/2020/Service/Report-112-Emergency-Room-Services---41122.pdf; MICH. DEP'T OF HEALTH & HUMAN SERVS., 2019 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY: EMERGENCY SERVICES FOR ACUTE CARE HOSPITAL BY TYPE OF SERVICE REPORT 112, at 5 (2020) [hereinafter 2019 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY], https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder90/Folder2/Folder190/Folder1/Folder290/Report_112_Emergency_Room_Services.pdf; MICH. DEP'T OF HEALTH & HUMAN SERVS., 2018 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY: EMERGENCY SERVICES FOR ACUTE CARE HOSPITAL BY TYPE OF SERVICE REPORT 112, at 5 (2020) [hereinafter 2018 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY], https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder3/Folder1/Folder103/Report_112_Emergency_Roo_Services.pdf.

172. 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5; 2019 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5; 2018 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5.

173. 2020 COURT CASELOAD REPORT, *supra* note 37; 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5.

174. 2020 COURT CASELOAD REPORT, *supra* note 37; 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5.

connected to treatment and instead cycle in and out of hospitals, emergency departments, courts, and jails.[175] The experience in Wayne County supports this conclusion.[176]

The Detroit Wayne Integrated Health Network (DWIHN), the community mental health agency for Wayne County, served about 43,543 persons with serious mental illness in the 2022 fiscal year (from October 1, 2021, to September 30, 2022) and about 89,360 persons with serious mental illness over the last five fiscal years (from October 1, 2017, to September 30, 2022).[177] Over the last five years, 16,000 petitions for involuntary treatment were filed in the Wayne County Probate Court for 9,000 individuals, many but not all of whom are served by DWIHN.[178] Six hundred of these individuals, less than 1% of the individuals petitioned, accounted for 36% of all petitions.[179] Seventy-six of these individuals had at least ten petitions in that time frame.[180] In the most recent fiscal year, the inpatient psychiatric hospitalization cost for these individuals was over $3.3 million.[181] One individual had sixteen emergency department visits.[182] Fifty-one percent of these individuals were booked and spent over 10,000 days in the Wayne County Jail, costing over $1.6 million.[183]

The 600 individuals in Wayne County who have repeatedly cycled through hospitals, emergency departments, and the probate court are doomed to continue this dismal cycle unless there is a change in practice. There are several reasons people do not get help.

Many people are transported to hospitals by law enforcement independent of the courts.[184] The officers often fill out petitions for treatment; however, chiefs of police from across the state report that many of these petitions are not filed with the court, and the individuals are often released from the emergency department within hours of arrival.[185]

Across Michigan, for individuals who are hospitalized and petitioned, courts do not hear nearly 60% of the petitions because the individuals are either discharged from inpatient psychiatric care, voluntarily signed in, or

175. *See* DETROIT WAYNE INTEGRATED HEALTH NETWORK, 2019 – 2020 ANNUAL REPORT, at 7 (2020), https://www.dwihn.org/documents-annual-report-2019-20.pdf.

176. *See id.* at 48.

177. E-mail from Manny Singla, Chief Info. Off., Detroit Wayne Integrated Health Network, to Author (Oct. 3, 2022, 11:14 AM ET) (on file with Author).

178. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. E-mail from Robert Dunlop, Chief, Wayne Cnty. Sheriff's Off., to Author (Sept. 7, 2022, 1:33 PM ET) (on file with Author).

184. *See* CIVIL COMMITMENT, *supra* note 151, at 1, 14.

185. *See Mental Illness: Hospitalization*, ACCESSKENT, https://www.accesskent.com/Courts/Probate/hospitalization.htm (last visited Sept. 15, 2022).

have signed a deferral before the hearing occurs.[186] This would not be a problem if these individuals were connected to outpatient treatment. Unfortunately, there is little evidence that these individuals are connected to treatment even though, to schedule a hearing, these individuals were screened, had two clinical certificates finding a need for hospitalization, and were hospitalized pending a hearing in seven days.[187] While the immediate threat of harm and the need for hospitalization may have dissipated, many of these individuals have evidenced a long history of nonadherence and require treatment to stay well and avoid repeat hospitalization.[188] For the tens of thousands of individuals in psychiatric crisis who visit emergency departments in Michigan every year, there is little evidence of a connection to community treatment following discharge from the hospital.[189] There are many reasons for the lack of connection.

At the time of initial hospitalization, the individual may request hospitalization as an informal voluntary patient.[190] If the hospital considers the individual to be clinically suitable, the hospital can approve the request.[191] Upon notice from the hospital of a voluntary admission, the court must dismiss any pending petition for admission unless it finds it "would not be in the best interest of the individual or the public."[192] However, if a person is suitable for hospitalization, it is likely they are suitable for AOT.[193] In the case of voluntary admission, without coordination with community treatment providers, it is likely that the person would not be connected to treatment.[194] For a petition seeking both hospitalization and AOT, one could argue that the request for AOT is still pending, and the hospital must provide testimony because the court is only required to dismiss the petition for admission.[195] Then, the court could enter an AOT order and intervene upon receiving notice of noncompliance from the treatment provider.[196]

The biggest challenge is apparently in the deferment process. Once a petition is filed and set for hearing, the court appoints an attorney, and the hospital must schedule a deferment conference within three days.[197] The hospital is required to give notice of the conference to the community

186. *See* MICH. COMP. LAWS § 330.1406 (2022).
187. *Id.* § 330.1452.
188. *Id.* § 330.1401.
189. *See* 2020 MICHIGAN CERTIFICATE OF NEED ANNUAL SURVEY, *supra* note 171, at 5 (demonstrating that psychiatric episodes are the top reason for emergency room visits in Michigan).
190. MICH. COMP. LAWS § 330.1411 (2022).
191. *Id.*
192. *Id.* § 330.1406.
193. *Id.* § 330.1468.
194. *See id.* § 330.1402a (explaining that it is not required for voluntary patients to consult with a community health services provider).
195. *Id.* § 330.1406.
196. *Id.* § 330.1468(d).
197. *Id.* § 330.1455(3).

treatment provider, the individual, and their attorney.[198] The deferment form has a blank space intended to identify who will supervise the outpatient treatment.[199] If the patient agrees to outpatient treatment, the hospital must "release the individual from the hospital to the outpatient treatment provider."[200]

Unfortunately, most hospitals in Michigan's largest counties do not conduct the deferment process as required by law because they fail to notify the community treatment provider of the deferment conference and release individuals to the outpatient treatment provider.[201]

For persons who have signed a deferral and have agreed to participate in outpatient treatment, the statute provides that if an individual refuses prescribed treatment or requests a hearing, treatment ceases and a hearing is scheduled.[202] The court can order a peace officer to transport the individual to the hospital, where they are held until the hearing is convened.[203]

However, if the community treatment provider does not receive notice of the deferment conference and the person is not released to the provider, the deferment is completely ineffective.[204] In effect, deferment is little more than a get-out-of-the-hospital-free card with no connection to community treatment.

Discharges pose a different problem. The general practice across the state has been that, if the hospital discharges the patient, the court dismisses the pending petition.[205] However, in St. Clair County, the court does not dismiss a petition seeking a combined order of hospitalization and AOT because the hospital's authority to discharge a patient does not include the authority to dismiss the petition as to AOT. [206] Hospitals that serve St. Clair County initially resisted the requirement of providing testimony for the AOT portion of the petition.[207] They are now compliant, and individuals are receiving treatment and are not being hospitalized or petitioned as often.[208]

198. *Id.* § 330.1455(5).

199. *See Request to Defer Hearing on Commitment*, MICH. CTS., https://www.courts.michigan.gov/4a7963/siteassets/forms/scao-approved/pcm235.pdf (last visited Sept. 15, 2022).

200. MICH. COMP. LAWS § 330.1455(9) (2022).

201. Zoom Meeting with Sojourner Jones, Cmty. Law Enf't Liaison, Detroit Wayne Integrated Health Network (June 29, 2020).

202. MICH. COMP. LAWS § 330.1455(9) (2022).

203. *Id.*

204. *See id*. § 330.1406.

205. *See id*. § 330.1476 (providing instructions to hospital directors and courts regarding a patient's discharge and pending petition).

206. *See id.*

207. *See generally* E-mail from John D. Tomlinson, J., St. Clair Cnty. Probate Ct., to Author (July 6, 2022, 12:01 PM ET) (on file with Author) (indicating that St. Clair County requires its hospitals to provide testimony).

208. *Id.*

Judge Tomlinson reports that instead of seeing four to five petitions per year for an individual, he may only see that individual every two to three years.[209]

When a court grants a petition and the individual is placed on a combined order, the statute requires hospitals to consult with the director of the AOT program before releasing an individual.[210] There is scant evidence of compliance with this aspect of the law.[211] Only the director of the outpatient treatment program can release the individual from the outpatient treatment order.[212] Releasing the individual from the hospital without complying with the law reduces the likelihood that the individual will be connected to the community treatment provider.[213]

VIII. THE PATH FORWARD

Mental health laws that promote recovery with early intervention and the use of AOT will not work without collaboration across systems led by courts. This requires engagement by all stakeholders and collaboration.[214] Courts are best positioned to act as facilitators to bring stakeholders together.[215]

The experience of several counties in Michigan has validated the importance and effectiveness of collaboration. This collaboration helps identify gaps in the system so that people in need of continuing treatment upon release from the hospital can secure such treatment.[216] Having hospital, court, and jail liaisons helps the process work and facilitates a smooth transition from system to system.[217]

The Genesee Health System (GHS) is a leader in the implementation of AOT.[218] They began by establishing a monthly community collaborators meeting that includes hospitals, emergency departments, the probate court, law enforcement, attorneys, and other agencies that provide services.[219] The

209. *See id.* (agreeing that the testimony requirement, despite discharge, has resulted in better outcomes for individuals).

210. MICH. COMP. LAWS § 330.1474(1) (2022).

211. *See id.* (framing Michigan's law regarding individuals who face a combined order for hospitalization and AOT).

212. *Id.*

213. *See id.*

214. NAT'L CTR. FOR STATE CTS., LEADING CHANGE GUIDE FOR STATE COURT LEADERS, at 4 (2022), https://www.ncsc.org/__data/assets/pdf_file/0025/78073/Leading-Change-Guide-for-State-Court-Leaders.pdf.

215. JUDGES' CRIM. JUST./MENTAL HEALTH LEADERSHIP INITIATIVE, JUDGES GUIDE TO MENTAL HEALTH DIVERSION, at 11–12 (2010), https://www.prainc.com/wp-content/uploads/2015/08/MHD-preview.pdf.

216. *See Assisted Outpatient Treatment Toolkit Bridges the Gap*, *supra* note 61.

217. *See id.*

218. *Assisted Outpatient Treatment (AOT) Program*, GENESSEE HEALTH SYS., https://www.genhs.org/AOT_Main (last visited Sept. 15, 2022).

219. *See generally id.* (explaining the framework and importance of the AOT program).

group discusses barriers and problem-solving.[220] GHS, the public mental health provider for Genesee County, runs the program.[221]

In determining whether to seek hospitalization or AOT for an individual, GHS looks to the immediacy of the risk of harm.[222] If the risk of harm is present but not high, GHS seeks AOT.[223] GHS has found that AOT is better for consumers by preventing adverse outcomes, stabilizing the individual, and giving the individual insight.[224]

The traditional method of police arrest—transport to a hospital and involuntary confinement pending a hearing that will, at most, result in a short hospital stay—has failed to promote recovery and reduce incarceration, emergency department visits, hospitalization, and homelessness.[225] Additionally, it may inflict trauma.[226] On the other hand, AOT is an evidenced-based practice that assures continuity of care and permits earlier intervention.[227] Most importantly, it saves lives.[228] GHS has found that in some cases in which the treatment team determines that an order for outpatient treatment is no longer needed, the consumer insists upon continuing the order because they feel the order causes them to comply with treatment, including taking prescribed medication.[229] When a court orders an individual to AOT, they are given a program handbook that describes how the program works, identifies the members of the treatment team, and informs the individual that they are a member of the treatment team.[230] The individual is informed that as they successfully progress, the level of court monitoring and treatment team monitoring will be reduced and may be lifted altogether.[231]

The individual is also given a document entitled Understanding Your Deferral for Mental Health Treatment and a second document entitled Understanding Your Court Order for Mental Health Treatment.[232]

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220. *Id.*

221. *Id.* Genesee County, with a population of 406,211, is the fifth most populated county in Michigan. *Michigan Counties by Population*, MICH. DEMOGRAPHICS BY CUBIT, https://www.michigan-demographics.com/counties_by_population (last visited Sept. 15, 2022).

222. *See* Telephone Interview with Jennifer Kimmel, *supra* note 70 (stating that the immediacy of the risk of harm governs whether hospitalization or AOT is the least restrictive, most appropriate treatment).

223. *Assisted Outpatient Treatment (AOT) Program*, *supra* note 218.

224. Telephone Interview with Jennifer Kimmel, *supra* note 70.

225. CIVIL COMMITMENT, *supra* note 151, at 13.

226. Diana Paksarian et al., *Perceived Trauma During Hospitalization and Treatment Participation Among Individuals with Psychotic Disorders*, 65 PSYCHIATRIC SERVS. 266, 267 (2014), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201200556.

227. JENNIFER KIMMEL, AOT PROGRAM MANUAL, at 2 (2020).

228. Telephone Interview with Jennifer Kimmel, *supra* note 70.

229. *Id.*

230. GENESEE HEALTH SYS., ASSISTED OUTPATIENT TREATMENT (AOT) PROGRAM HANDBOOK, at 4 (2022).

231. *See id.* at 7–8.

232. *See* GENESEE HEALTH SYS., UNDERSTANDING YOUR DEFERRAL FOR MENTAL HEALTH TREATMENT (2022); GENESEE HEALTH SYS., UNDERSTANDING YOUR COURT ORDER FOR MENTAL HEALTH TREATMENT (2022).

The individual is advised that in the event of failure to comply with the treatment plan, the court may extend the length of time the individual is in the AOT program, increase the frequency of court visits, order a review of the treatment plan, order the individual to be picked up and evaluated for hospitalization, or order attendance at a court hearing.[233]

As of May 2022, GHS was monitoring 329 AOT cases per month and that number was steadily growing.[234] Compliance with treatment was high, with 95% of the individuals compliant enough with their court order so as to not require a court hearing.[235] Persons in AOT had a higher rate of hospital recidivism prior to being placed on an AOT order compared to individuals receiving treatment from GHS who were not on AOT.[236] After seven to sixteen months, the hospital recidivism rate dropped dramatically for those on AOT and was at the same level as those not on AOT.[237] At the same time, incarceration dropped.[238] In May 2022, only eight of the 329 individuals on AOT were incarcerated.[239] The bottom line is that persons in AOT experienced less time in jail and hospitals, were in better health, and their care was less expensive.[240]

Other counties are also beginning to use AOT as intended by the change in the law. Public leadership in Wayne County[241]—including the mayor of Detroit; the Wayne County executive; the Wayne County sheriff; and the chief judges of the circuit, probate, and district courts—has come together to improve the delivery of mental health services.[242] That leadership has convened the stakeholders to collaborate and bring order to a fragmented delivery system.[243] The process began with a SIM-mapping exercise that led to the county funding the creation of a Behavioral Health Unit (BHU) within the probate court to manage collaboration across healthcare systems and mental health treatment providers.[244]

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233. ASSISTED OUTPATIENT TREATMENT (AOT) PROGRAM HANDBOOK, *supra* note 230, at 5–6.

234. Genesee Health Sys., *GHS AOT Program*, ZOOM (June 10, 2022) (on file with the Author).

235. *Id.*

236. *Id.* The hospital recidivism rate for persons before they were placed on an AOT program was 28.58%. *Id.*

237. *Id.* Hospital recidivism for persons who have been on AOT from seven to sixteen months was 10.61% as of May 2022—a drop of nearly 63%. *Id.*

238. *See id.*

239. *See id.*

240. *Id.*

241. Wayne County is Michigan's largest county with a population of 1,793,561. *Michigan Counties by Population*, *supra* note 221.

242. *Wayne County Behavioral Health Pilot Project Helping 'Familiar Faces' in the Justice System*, MICH. CTS. (July 13, 2022) [hereinafter *Wayne County Behavioral Health Pilot Project*], https://www.courts.michigan.gov/news-releases/2022/july/wayne-county-behavioral-health-pilot-project-helping-familiar-faces-in-the-justice-system/.

243. *Id.*

244. *See* ERIN COMARTIN ET AL., ACTIVITY ACROSS THE SEQUENTIAL INTERCEPT MODEL & DIVERSION PROGRAM OUTCOMES, at 5 (2021), https://behaviorhealthjustice.wayne.edu/diversion/activity_across_the_sim_mmdhc_cbhj_09_13_21.pdf.

When issuing orders for treatment, the Wayne County Probate Court almost always includes AOT.[245] In the first six months of 2022, 479 individuals were placed on AOT; however, 136 do not appear to have been assigned to a provider.[246] In addition, for the 332 individuals assigned to one of the sixteen agencies[247] providing mental health care, the highest performing agency provided services to 77% of the individuals to whom they were assigned while the lowest performing agency was only providing services to 30% of the individuals to whom they were assigned.[248] The rest had not begun receiving timely service. For the process to work most effectively, 100% of the persons ordered to receive AOT should receive timely services. In order to benefit individuals receiving court-ordered AOT, the culture must change to achieve full service.

The court, BHU, and DWIHN provide training and communication to hospitals, Crisis Stabilization Units (CSU), psychiatric urgent care facilities, and clinically responsible service providers, informing them of their obligations under the new laws and describing mechanisms to assure compliance.[249]

For those individuals with eligibility issues, a subcommittee of select stakeholders, including CCBHCs, is developing a memorandum of understanding so that individuals needing help can be routed to an entity that can serve them.[250] Often, public mental health agencies cannot serve persons who are not eligible for Medicaid or who have insurance due to the legislature's lack of general-fund appropriations.[251] The subcommittee is working to ensure those individuals are routed to a CCBHC.[252]

At the state level, the MMHDC[253] has engaged the Center for Behavioral Health and Justice at Wayne State University[254] to develop an AOT Toolkit that will serve as a resource for the key stakeholder groups associated with the AOT process across Michigan, including (1) courts, (2) law enforcement, (3) mental health providers, (4) acute care settings, (5) hospitals and

245. *Wayne County Behavioral Health Pilot Project*, *supra* note 242.

246. *See id.* (explaining statistics regarding the implementation of AOT in Wayne County).

247. *See id.* Known as Clinically Responsible Service Providers (CRSPs). *Id.*

248. *See generally id.* (explaining the importance of connecting individuals with community treatment).

249. E-mail from Kristina Morgan, Behav. Health Unit Liaison Manager, Wayne Cnty. Probate Ct., to Author (Apr. 22, 2022, 11:05 AM ET) (on file with Author).

250. MICH. DEP'T OF HEALTH & HUM. SERVS. BEHAV. & PHYSICAL HEALTH & AGING SERVS. ADMIN., MI CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) HANDBOOK VERSION 1.4, at 1, 19 (2022), https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder43/Folder3/Folder143/Folder2/Folder243/Folder1/Folder343/CCBHC_Demonstration_Handbook.pdf.

251. *Id.* at 29.

252. *Id.* at 53.

253. Mich. Dep't of Health & Hum. Servs., *Mental Health Diversion Council*, MICHIGAN.GOV, https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mhdc (last visited Sept. 15, 2022).

254. *Id.*

emergency departments, (6) advocates, and (7) families.[255] Each stakeholder group will understand its role in addressing mental illness and how it must collaborate with other stakeholders to improve the lives of those suffering from serious mental illness.[256]

While it is clear that Michigan has been slow to implement the improvements in the law, it is equally clear that momentum is building as hospitals, emergency departments, and law enforcement recognize the important role they can play in achieving the best possible outcome for persons with mental illness. As the roll-out of the expanded use of AOT continues, hundreds of individuals in Michigan have finally been connected to treatment that has improved their lives.[257] Earlier intervention with follow-up care in the community by stakeholders who are working collaboratively has made all the difference for these individuals.[258]

Michigan's constitution promises that programs and services for the care, treatment, and rehabilitation of its citizens with serious mental illness shall always be fostered and supported.[259] Michigan is now beginning to deliver on that promise.

255. *Assisted Outpatient Treatment*, WAYNE STATE SCH. OF SOCIAL WORK CTR. FOR BEHAV. HEALTH & JUST., https://behaviorhealthjustice.wayne.edu/aot (last visited Sept. 15, 2022).

256. *Id.*

257. *See* DETROIT WAYNE INTEGRATED HEALTH NETWORK, MINUTES TO PROGRAM COMPLIANCE COMMITTEE MEETING, at 34 (June 8, 2022), https://www.dwihn.org/board-PCC-June2022-agenda.pdf (citing ninety-two total AOT orders during the second quarter of 2022).

258. *Wayne County Behavioral Health Pilot Project*, *supra* note 242.

259. MICH. CONST. art. VIII, § 8.