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International Journal of Law and Psychiatry
27 (2004) 65–77

INTERNATIONAL JOURNAL OF
LAW AND
PSYCHIATRY

Managed mental health care's effects on arrest and forensic commitment

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1. Introduction

Reducing the use of inpatient treatment has been a consistent theme of American mental health policy for the last half century and, over that time, has been the focus of numerous service system interventions. Among these was passage of reformed civil commitment statutes by state legislatures across the country. These reforms, enacted mainly in the late 1960s and early 1970s, limited the availability of involuntary psychiatric hospitalization as a means for managing deviant behavior in the community, and made a significant contribution to expanding the rights of persons with mental illness (Appelbaum, 1994).

But the passage of these reforms was also seen as having a number of unintended and less desirable sequelae. In particular, their enactment was followed by reports of increased involvement in the criminal justice system among persons with mental illness, many of whom were former state hospital patients—an outcome that came to be referred to as the "criminalization" of mental illness (Abramson, 1972).

By the 1990s, the use of state hospitals had declined substantially, and the principal locus of inpatient treatment for severe mental illness had shifted to general hospitals. Many advantages were cited in support of this shift, but chief among them, perhaps, was that a portion of the cost of treatment provided in these settings would be borne by the federal government through the Medicaid program (Dorwart & Epstein, 1993; Fisher, Dorwart, Schlesinger, Epstein, & Davidson, 1992). But this cost shifting soon contributed to a growing fiscal crisis in these programs, and many states introduced managed care to control the spiraling cost of their Medicaid behavioral health programs.

The implementation of managed mental health care was driven largely by economic, rather than civil, liberties concerns. Nevertheless, like the nationwide civil commitment reforms enacted two decades

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0160-2527/$ - see front matter © 2004 Elsevier Inc. All rights reserved.
doi:10.1016/j.ijlp.2003.12.002

earlier, managed care focused primarily (though not exclusively) on limiting the use of inpatient care. Moreover, viewed broadly, the practices employed by managed care organizations (MCOs) working in Massachusetts and other states to curb unnecessary hospitalization have been similar in many key respects with those mandated in reformed civil commitment statutes. Both specify clinical/behavioral criteria for hospitalization and employ mandatory prescreening processes to assess persons relative to those criteria. In addition, both seek to limit the duration of hospitalization through mandated review of the patients' clinical status—civil commitment through regular court hearings, managed care through the mechanism of concurrent review. The similarity in goals and procedures developed as features of the two interventions raise the question that we address in the study described here: Has one of the most frequently noted consequences of civil commitment reform, the increased criminal justice system involvement among persons with mental illness, also occurred following the introduction of managed care?

1.1. Medicaid managed mental health care: the Massachusetts experience

In the early 1990s, Massachusetts, like many other states, was experiencing severe budget shortfalls. Trimming the state's mental health budget by shifting a portion of the cost of inpatient treatment to the federal government through the Medicaid program emerged as among a range of possible remedies. In pursuit of this agenda, an effort was undertaken to enroll as many clients of the Massachusetts Department of Mental Health (DMH) as possible in the state's Medicaid program (Callahan, et al., 1995; Dickey et al., 1995). Realizing the expected savings from this cost-shifting effort would prove more complicated, however. As in many other states, Medicaid expenditures were soaring and outlays from Medicaid's behavioral health accounts were increasing more rapidly than were those for general health care. In order to stem this increase, Massachusetts applied for and was granted a 1915b waiver from the Health Care Financing Administration, allowing the state's Division of Medical Assistance to implement a managed care program for its behavioral health plans. A proprietary MCO was retained to administer the plan. When the main features of the initiative took effect in October 1992, Massachusetts became the first state in the nation with a statewide Medicaid managed mental health care program.

The outcomes of the Massachusetts initiative have been described in substantial detail elsewhere (Callahan et al., 1995; Dickey et al., 1995; Frank & McGuire, 1997) and need not be recounted here, except to outline briefly the major operational components of the plan and its principal outcomes as they pertain to inpatient treatment. Among the steps taken by the MCO in implementing the managed care plan was the development of prescreening or precertification protocols for approving hospital admissions and the use of a concurrent review process to monitor progress and facilitate discharge planning. A number of changes in inpatient use occurred within the first year of the MCO's operation. Of particular interest here was a 15% reduction in Medicaid-reimbursed hospital days in general and private psychiatric hospitals. Significantly, this reduction was achieved without recourse to "dumping" patients in state hospitals; indeed, over this same time period, state hospital use also fell by roughly 15% (Callahan et al., 1995; Dickey et al., 1995). These achievements notwithstanding, many advocates for persons with severe mental illness expressed serious concerns about potential undesirable consequence. Given the increased attention being paid nationally to the criminalization of mental illness, it is not surprising that one such concern, as articulated by the mother of a young man with severe mental illness, was that he and others like him would "all end up in jail."

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