

# Privatized Managed Care and Forensic Mental Health Services

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**Managed care for mental health services, which began in the private, commercial sector, has spread over the past few years to the public mental health sector as well. Recently, states have begun considering whether to include the forensic population within their privatized managed care systems. This article explores some of the complexities and special challenges unique to forensic services and notes some of the problems that might be incurred if the forensic population were included in a managed care system.**

Managed care for mental health services, which began in the private, commercial sector, has spread over the past few years to the public mental health sector as well. Some states have recently “carved out” mental health care for their Medicaid and/or seriously mentally ill populations. This means that the states have contracted with private managed-care organizations (MCOs) to provide those services on a capitated basis (examples include Massachusetts, Tennessee, and Utah). An essential element of these systems is that a private entity is entrusted with the responsibility for managing the provision of services, with funding coming from public sector sources. The fact that the care is managed is not the novel feature, since

public sector systems also manage care by utilizing incentives for saving resources. The use of private vendors is also not innovative, since many public systems currently rely on private hospitals and vendors to provide services. Rather, the significant change is that the private entity is entrusted with the responsibility for managing the care of these public sector clients (i.e., making decisions about availability of treatment and allocation of resources).

A major motivation for the use of such arrangements is cost savings, attributable in large part to the decrease in the use of expensive inpatient psychiatric hospitalizations. Thus, savings are maximized by diverting clients from inpatient hospitals to less costly services in the community. This development is philosophically consistent with a desire to limit involuntary treatment and to find the least restrictive

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alternative. However, concerns have been raised about the special needs of patients with chronic mental illnesses and how they present challenges to the privatized managed care model.<sup>1,2</sup> These concerns include that the patients are particularly disabled and therefore require services on multiple levels and that their impairments are of a chronic nature requiring long-term, continuous care.

As this trend toward managed mental health care continues, the issue of how to include forensic populations in such systems has gained more attention.<sup>3</sup> Many of the challenges in using the managed care model with a severely mentally ill population also apply to the forensic population. This article will focus on some of the special issues that apply to the forensic system and that present major challenges for extending the model of privatized managed care to the delivery of services to the forensic population. For the purpose of this discussion, the following definition of forensic mental health services, developed by the State Mental Health Forensic Directors<sup>3</sup> will be used: "Evaluation and treatment services available to persons who have a mental illness and come into contact with the criminal justice system. Such services may be provided either pretrial, postconviction, or following acquittal by reason of insanity." These services include: (1) pretrial evaluation services (such as evaluations for competency to stand trial and criminal responsibility, whether performed in outpatient or inpatient settings); (2) pretrial treatment services (such as treatment for restoration to competency); and (3) post-adjudication services (such as evaluation

and treatment of insanity acquittees, both in inpatient and community settings).

In parallel to the civil population, the new element is not that care is being managed or resources reallocated. In the forensic arena, for example, most states have constructed systems that provide incentives for less restrictive and less costly outpatient forensic evaluations.<sup>4</sup> This has been largely noncontroversial because it results not only in cost savings but in less restrictive treatment. Data gathered from Massachusetts over the past decade demonstrate this type of "public managed care" in effect. In 1985, the Commonwealth of Massachusetts Department of Mental Health (DMH) developed a Division of Forensic Mental Health with a mandate that included overseeing the provision of high quality forensic evaluations to the courts of the Commonwealth. The Division built on existing court clinics (which were poorly staffed, not available for many courts, and not integrated into the larger DMH service delivery system) and augmented these with specially trained forensic clinicians. Data from the DMH indicate that in the 10 years following the development of the Division, there was a significant decrease in the number of defendants referred to inpatient facilities for pretrial forensic evaluations (see Fig. 1). This effect was not immediate, which suggests that it takes several years before system-wide changes achieve the desired impact. Additional data from studies in western Massachusetts confirm that this decrease was due to the establishment of the court clinics. Geller *et al.*<sup>5</sup> found that despite a significant decrease in civil admissions to

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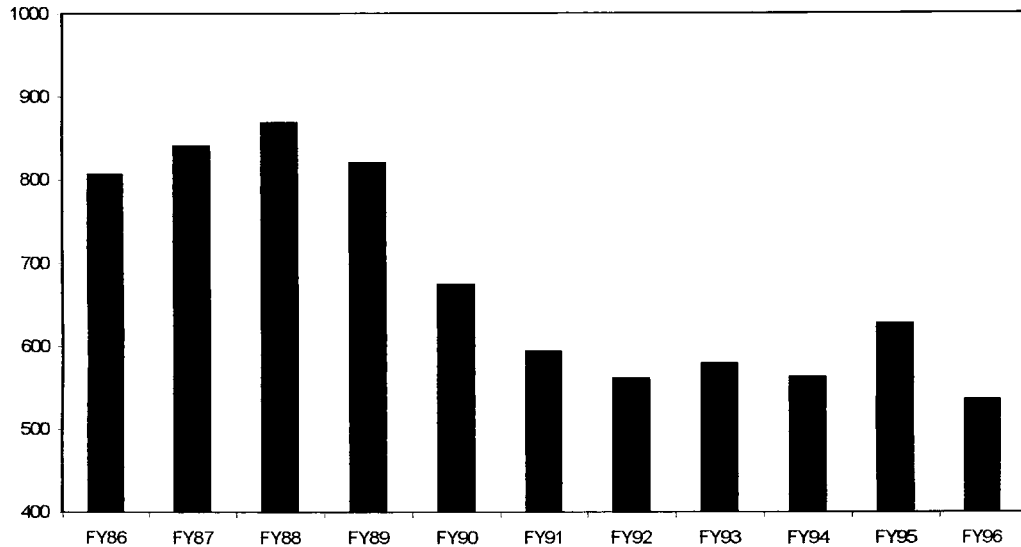


Figure 1. Adult pretrial forensic admissions DMH hospitals in Massachusetts FY86–FY96.

Northampton State Hospital (the state hospital serving western Massachusetts) between 1978 and 1984, the number of pretrial forensic admissions to that facility remained constant. Packer,<sup>6</sup> however, found that after the establishment of the court clinic in 1986 in Springfield (the major city from which defendants were sent to Northampton State Hospital), there was a significant decline in forensic admissions to the hospital.

These data indicate that indeed the public sector has been managing forensic care for many years now, so that the attempt to maximize efficiency of service and limit use of inpatient resources is not innovative. The new wrinkle is that states are now considering turning to the private sector and providing financial incentives for them to take over this function. This shift, however, raises significant issues and concerns about whether MCOs are

currently prepared for the special challenges posed by forensic clients and whether the states have adequate mechanisms to monitor the performance of the MCOs.

These challenges are due both to client characteristics as well as legal and political considerations. Those forensic clients who become involved with the public sector have engaged, by definition, in criminal behavior, often involving violence. Many private MCOs, as well as hospitals and community providers, do not have experience working with such clients and have not developed specialized risk assessment and risk management procedures. The assessment and treatment of these individuals requires additional expertise beyond the standard clinical approaches. Focusing on psychiatric symptom remission, for example, is not sufficient. Rather, the provider must

be familiar with the factors that increase the risk of violent behavior and must be able to identify the particular risk factors for the individual client.<sup>7</sup> As many managed care organizations have focused on acute symptom reduction to limit inpatient hospitalization, working with forensic populations requires a change of clinical focus, including more attention to personality variables and violence history.

In terms of legal considerations, the criteria for hospitalizing forensic patients are different from those for civil populations. For instance, some jurisdictions allow inpatient evaluations of competency to stand trial and criminal responsibility, and in some states defendants who are adjudicated incompetent to stand trial may be hospitalized solely for restoration to competency. Utilization review mechanisms developed for civil patients will be inadequate and misleading for the forensic population.

Furthermore, forensic patients who do not otherwise meet clinical criteria for hospital level of care nevertheless may be appropriate for inpatient hospitalization because of the need for further observation and assessment of competency or criminal responsibility that cannot be completed in other settings (e.g., a defendant suspected of malingering). More significantly, hospitalization in some cases may be appropriate because the alternative is to attempt treatment in a correctional setting that may not have the resources or the required therapeutic environment. Unlike the situation for civil patients, diversion to a partial hospitalization or outpatient program may

not be available because of the client's legal status.

Additionally, standards for successful management of forensic clients may differ from standards used for civil clients. For example, California tracked insanity acquittees who had been released into the community and found that these individuals were rehospitalized at a high rate.<sup>8</sup> From the usual perspective of managed care, this would be considered problematic. However, within the forensic context this rehospitalization rate represented a success; as a result of close monitoring in the community, these individuals received prompt treatment and were psychiatrically stabilized before becoming involved with the criminal justice system. The data confirmed that these individuals who were closely monitored under a conditional release program had a lower rearrest rate than a comparable group who had been unconditionally discharged from psychiatric hospitals. Thus, for these clients quicker and easier access to hospital level of care would be considered an effective and efficient use of mental health resources.

For continuing care forensic patients (e.g., those committed as not guilty by reason of insanity), the criteria for release to the community may also differ from civil criteria. In some jurisdictions, the burden of proof for discharge has been shifted to the client.<sup>9</sup> In other states<sup>10</sup> the authority to discharge insanity acquittees has been granted to special boards (Psychiatric Security Review Boards). The mandate of these boards is predominantly the protection of the public; for example, the Oregon statute specifically states: "In

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determining whether a person should be committed to a state hospital, conditionally released or discharged, the Board shall have as its primary concern the protection of society.”<sup>11</sup> Although clinical considerations are still essential in such decision making, this statutory language creates a different calculus in weighing public safety versus treatment considerations. This emphasis on public safety is not only a legal concern but a political one as well. Although the incidence of insanity acquittals is low, the public continues to overestimate this rate and pays inordinate attention to this issue.<sup>9</sup> Significant changes in laws have been promulgated in reaction to single, highly publicized cases. Furthermore, negative publicity brought by such cases can have repercussions for the entire mental health service delivery system, threatening the quality of care for large numbers of clients, both forensic and civil. Thus, private MCOs that choose to become involved with this population need to develop different expectations and criteria for allocation of resources.

The issues described above represent challenges not only to potential MCOs but also to the state agencies (e.g., departments of mental health) that will retain the ultimate responsibility for ensuring that appropriate services have been provided by the MCO. The following elements, at a minimum, would need to be in place in order for a state to properly monitor the delivery of forensic services by the private sector:

1. The state would need to develop a specialized utilization review tool specifically geared toward forensic clients. The purpose of such an instrument would be to determine whether inpatient facilities are being properly used for forensic clients. This tool needs to be tailored to accommodate the statutes of the particular state (e.g., some states allow inpatient forensic admissions for misdemeanors, while others restrict such admissions to felonies; states differ regarding criteria for continued commitment of incompetent defendants; states differ in their criteria for discharge of insanity acquittees).
2. The state would need to utilize a quality assurance tool, such as the instrument used in Massachusetts, to evaluate the quality of forensic evaluations provided to the courts.<sup>12</sup> Although general quality measures will be consistent across states, there will need to be individual tailoring here as well (e.g., some states require that the reports include an opinion on need for care and treatment, while others do not; some statutes call for an “ultimate issue” opinion, while others do not).
3. The state would need to ensure that forensic evaluations and assessments are performed by professionals with appropriate training and credentials. A number of states already have such mechanisms in place (e.g., Massachusetts, Michigan, Virginia). However, if such functions are turned over to private MCOs, the need for standards will become even more important.
4. The state would need to ensure that

decisions about release of forensic patients include a standardized risk assessment. The state mental health authority should review any such proposed risk assessment instruments to ensure that they incorporate the most updated research and knowledge regarding violence risk assessment. An example of such an instrument is the Violent Behavior Assessment Form used in Massachusetts.<sup>13</sup>

5. The state would need to develop mechanisms to monitor the prevalence of severely mentally ill clients within the criminal justice system (including correctional facilities). It is important to develop baseline measures to assess whether system changes (such as a move to a privatized managed care model) influence the treatment of those individuals with mental illness who are involved with the courts. For instance, it is essential to monitor whether incentives to divert from hospitalization lead to the incarceration of increasing numbers of individuals with severe mental illness.

Implementation of these recommendations would provide a foundation for the public mental health agency to set standards for and monitor the performance of a private MCO. However, formidable obstacles to the successful implementation of privatized managed care to forensic populations would still remain. Most private hospitals do not have experience providing mental health services to forensic clients, particularly those with significant histories of violence. Furthermore, al-

though cost savings is a major factor propelling the movement toward privatized managed care, the system would have to accommodate substantial limitations in the ability of MCOs to limit costs. Specifically, ultimate control of admissions and discharges will not be within the purview of the MCO but will continue to reside with the courts. Thus, the MCOs will not be able to employ as successfully the same techniques they currently use with civil populations (e.g., pressuring hospitals to discharge by withholding payment if the MCO does not deem additional care to be medically necessary). If the court deems the individual to be in need of continued care, that decision will overrule any clinical decision-making mechanism the MCO may choose to implement.

These issues do not necessarily represent insurmountable obstacles to the privatization of the forensic mental health service delivery system. However, they do present significant challenges that must be met and suggest that states should carefully weigh the costs and benefits before including forensic populations within the privatized managed care system. On the other hand, there are potential risks to excluding the forensic population from the managed care system. Such an exclusion creates a dual system of care (i.e., a privatized system for civil patients and a public system for forensic patients). States choosing to employ a dual system would have to ensure that forensic clients are not relegated to a second-class level of care and that adequate community resources are available for these individuals. Attention also has to be

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paid to the interface between the two systems to ensure that there are clear criteria for determining when an individual is considered a "forensic" client. Furthermore, monitoring needs to be in place to ensure that such a system does not provide incentives to criminalize individuals with mental illness.

A recent survey of the states<sup>3</sup> reveals that only a few states (e.g., Tennessee) have begun to incorporate forensic services within their managed care plans. By contrast, Massachusetts has specifically excluded forensic services from its privatized managed care model for *acute* psychiatric services. Analysis of data over the next few years from these states (i.e., Massachusetts and Tennessee) will provide useful information about the relative merits of each approach.

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