



**PACA MH/DS**

PENNSYLVANIA ASSOCIATION OF COUNTY  
ADMINISTRATORS OF MENTAL HEALTH  
AND DEVELOPMENTAL SERVICES

# **Pennsylvania's Mental Health Procedures Act**

## **White Paper**

*Adopted by PACA MH/DS Board 2016*

### **EXECUTIVE SUMMARY**

Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS) has developed a document which begins with a brief review and history of the Mental Health Procedures Act (MHPA) and community services designed to support and care for people with mental illness in Pennsylvania. After an evaluation of trends and recent research, the paper proceeds to identify principles that will serve as a foundation for improved access to mental health crisis services and appropriate diversions.

This paper is consistent with the Department of Human Services Secretary's overarching policy goals of "serving people in the community" wherever possible and enhancing "value and efficient/effective use" of the Commonwealth/Department's resources. (Pennsylvania Department of Human Services, n.d.) Outpatient civil commitment/assisted outpatient treatment is recognized by the federal agencies and federal law as an evidenced based treatment option for individuals with Serious Mental Illness.

PACA MH/DS supports the overarching goals of the MHPA and recommends an amendment, to add an alternative pathway to the traditional involuntary commitment process. While we will always assert that voluntary pathways to treatment and recovery are preferred, we contend that the new outpatient option outlined, provides an enhanced level of access to care for individuals at risk of self-harm, dangerous behavior or incarceration; in a way that will promote the most appropriate, least restrictive and integrated interventions possible.

## **VISION STATEMENT**

PACA MH/DS envisions a mental health system that provides a continuum of appropriate and realistic pathways towards recovery. The overarching goal for individuals that are served by our system, is to provide a well-constructed array of care that offers evidence based interventions and diversions to assure individual and community safety, while promoting hope, healing and resiliency.

## **BACKGROUND STATEMENT**

Pennsylvania has a rich and progressive history in addressing the needs of individuals with mental illness beginning in the late 1700's with Dr. Benjamin Rush the "Father of American Psychiatry" and his enlightened attitude regarding the humane treatment of those with mental illnesses. (Penn Medicine, 2017). That tradition continued with the groundbreaking passage of the 1966 Act. (MH/ID Act, 1966)

In 1966 the Pennsylvania General Assembly passed one of the first state laws regarding community services to individuals with intellectual disabilities and mental health conditions: the Community Mental Health/Intellectual Disabilities Act. The 1966 Act created a foundation for community services by defining county and state responsibilities. Counties were given responsibility for creating and managing a core of services to assist individuals in their communities with state oversight. The community service system has grown in numbers and complexity since the passage of the legislation. (MH/ID Act, 1966)

The movement from hospital based psychiatric approaches to community based services began with the 1966 Act, which served as the framework for the Mental Health Procedures Act in 1976. Adjustments have occurred over time. (MH Procedures Act, 1976)

The transition continued into the early 1970's as federal funding became available including Medicaid and Medicare to provide support for individuals with mental illness. It was during this time period that much of the existing public behavioral health framework was constructed. The Act created a foundation for community services funded by state and federal dollars with the stated goal of helping individuals transition to and stay permanently in their communities. The MHPA adopted a standard that is common for commitment throughout the nation:

*Whenever a person is severely mentally disabled and in need of immediate treatment, he may be subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself. (MH Procedures Act, 1976)*

## **COMMUNITY BASED SERVICES**

Although the commitment process remains essentially unchanged since the legislation was passed, the state hospital and community based service delivery have evolved significantly over the past 40 years. Some of the changes that have occurred since MHPA's inception including the closing of several PA State Hospitals (PA Office of Mental Health and Substance Abuse Services, personal communication, February 21, 2017)

Pennsylvania state hospital closures as of January 1, 2017:

1. 1979 Holidaysburg State Hospital
2. 1980 Retreat State Hospital
3. 1980 Embreeville State Hospital
4. 1981 Eastern Pennsylvania Psychiatric Institute
5. 1984 Dixmont State Hospital
6. 1990 Philadelphia State Hospital
7. 1992 Woodville State Hospital
8. 1996 Somerset State Hospital
9. 1997 Eastern State School and Hospital
10. 1998 Haverford State Hospital
11. 2006 Harrisburg State Hospital
12. 2008 Mayview State Hospital
13. 2010 Allentown State Hospital
14. Fairview Transferred to Department of Corrections (DOC)
15. Lawrence Frick (Cresson) transferred to DOC

There are several influences beyond the state hospital closures that have impacted the mental health system, below are some examples of the legislation and modifications that have reformed our system to date.

- Insanity Defense Reform Act of 1984 reconstructing Not Guilty by Reason of Insanity (United States v. Freeman, 1986)
- 1999 Olmstead Decision creating the right to treatment in the least restrictive environment
- 1999 Kendra's Law in New York establishing strict standards for assisted outpatient treatment<sup>1</sup>
- 2010 enactment of the Affordable Care Act
- A new generation (atypical) psychotropic drug, Clozapine, approved by Food and Drug Administration (FDA) (Cullen et al, 2008, Atypical antipsychotics)
- Eleven atypical (new generation) psychiatric medications with FDS approval available in 2017
- Act 194 of 2004 established the Mental Health Advanced Directives Act

In 2013 The County Commissioners Association of Pennsylvania adopted a new plank to its platform to support a comprehensive legislative review and evaluation of the Commonwealth's Mental Health Procedures Act, and accompanying policy and procedure for voluntary and involuntary mental health commitments, in close collaboration with counties. (County Commissioners Association of PA, 2015)

We believe that any effort to ascertain the Act's applicability and relevance must also take into account societal changes and the resulting adaptations within behavioral healthcare community that have occurred since the Act's inception, as well as the advancements made in treatment modalities outlined above – especially the availability of new generation medications and the introduction of evidence based practices. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Report, there are 21 evidence based programs and practices for mental health treatment currently in practice in the Commonwealth that did not exist in 1976. It is a well-documented fact that a person with mental illness is much more likely to be the victim of a violent crime than to ever perpetrate one (Campbell, Stefan, & Loder, 1994).

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1. The Kendra's Law findings were published in a final report on the NY Office of Mental Health's Interim Report on Kendra's Law retrieved from [https://www.omh.ny.gov/omhweb/kendra\\_web/finalreport/intro.htm](https://www.omh.ny.gov/omhweb/kendra_web/finalreport/intro.htm)

PACA MH/DS must and does acknowledge the series of tragic events that have occurred nationwide in recent years including the shootings on the Virginia Tech Campus<sup>2</sup> and at the cinema in Colorado<sup>3</sup>. In fact, in these two cases the perpetrators were individuals who had been experiencing mental illness and were either not receiving treatment or were not adherent with prescribed treatment. In these cases, the friends and family of the perpetrators have publically expressed regret that they recognized clear signs that there was an impending serious problem with their loved one's mental state and wished that they had been given better options to intervene and help divert the person into appropriate care before tragedy occurred.

If an alternative pathway for community based treatment had existed the profound tragedies suffered not only by the communities of Blacksburg, Virginia and Aurora, Colorado but our country may have been prevented. PACA MH/DS understands that there are many scenarios that can occur, but having an additional path to treatment available will certainly enhance the opportunity for a hopeful outcome to the situations involving a person who is decompensating.

The events discussed above present new challenges to county programs and should engender a shift in our rationale and approach in responding to individuals with severe mental illness. The events outlined should also result in an examination of our ability to support individuals in need of treatment and to protect them and the community at large. In response to these tensions, PACA MH/DS examined the commitment laws across the nation to ascertain whether the MHPA remains the most effective approach. We concluded that the basic standards contained in the current law for inpatient commitment are appropriate and still the most commonly used throughout the nation.

A potential expansion of the standard will make the law more effective and offer a new path to treatment. Over 46 states have changed their civil commitment criteria to reflect substantive differences between inpatient and outpatient standards to ease the use of/access to Assisted Outpatient Treatment (AOT) for vulnerable populations. (Treatment Advocacy Center, 2016). A civil – not a criminal – procedure, AOT is authorized by the civil commitment sections of state statute and typically adapted to local needs, practices and policies.

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2. See CNN Website for Virginia Tech Shootings Fast Facts retrieved at <http://www.cnn.com/2013/10/31/us/virginia-tech-shootings-fast-facts/>

3. See CNN Website for Colorado Theater Shooting Fast Facts retrieved at <http://www.cnn.com/2013/07/19/us/colorado-theater-shooting-fast-facts/>

## POTENTIAL NEW PATHWAYS TO SERVICES

Several states have used the terms “gravely disabled” or “chronically disabled” or “persistently or acutely disabled” when considering a commitment standard regarding someone who will most probably become a risk to themselves or others in the short term; is clearly symptomatic with mental illness; and may have a known history of cyclical psychiatric issues. Individuals who are treatment resistant in the past, often risk further deterioration if diversion to appropriate treatment does not occur. There is a need to have an adequate medical evaluation by a qualified medical doctor. An example of a standard currently in use by Arizona is included below:

ARIZ. REV. STAT. § 36-501(31). "Persistent or acute disability" means a severe mental disorder that meets all the following criteria:

- (a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality.
- (b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.
- (c) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.

In Ohio, the legislature included in the definition of a “mentally ill person subject to court order” a new 5<sup>th</sup> criteria which establishes the standard for outpatient commitment. 5122.01

Hospitalization of mentally ill definitions. As used in this chapter and Chapter 5119 of the Revised Code. A key safeguard of this new Ohio outpatient criteria is the explicit recognition that a person who only meets the outpatient standards (subsection 5) is not subject to involuntary inpatient commitment.

In regards to treatment, it is not our purpose to imply there is a “cure” to the illness, but rather an effort to reduce the symptoms and provide a pathway to treatment. PACA MH/DS proposes

additional criterion for commitment modeled on the successful examples above in use in other states as a means to intercept and prevent an impending crisis that would incapacitate the person or create a true danger to themselves or others. Several states have moved away from focusing on dangerousness as a pre-condition for a person with a serious mental illness to receive outpatient treatment. They now use a standard based instead on whether or not a person safely can care for him or herself.

Individuals with documented serious mental illness are individuals who are the priority for community behavioral health services. This recommendation for expanding the current established standards will clearly subject a higher percentage of these individuals to the commitment process. PACA MH/DS takes this approach with caution. However, our concern for protecting civil liberties of a person with a serious mental illness, must be balanced with the important concern for the safety of those individuals and the potential danger to others in the community. Moreover, as the current process essentially requires people with a serious mental illness to become dangerous before we can support them, the practical effect is to criminalize mental illness. In Pennsylvania, a person with a serious mental illness is twice as likely to end up in jail as to receive treatment. According to the Pennsylvania uniform crime reporting system data, approximately 5,000 people with serious mental illness are arrested each month in the Commonwealth and at least 20 percent of our prison population suffers from mental illness. (Pennsylvania uniform crime reporting system, 2016).

The primary condition of the proposed new criterion is that an individual must clearly meet the definition of persistently or acutely disabled coupled with a clinical determination that the individual is unlikely to survive safely in the community and documented evidence of previous failures to comply with treatment resulting in involuntary hospitalization or acts of violence. Documentation would need to be provided in the form of available medical records or other verifiable evidence of the individual's mental health history.

Community programs are aware of individuals receiving services and understand their potential to escalate when they are not receiving proper treatment. An additional criterion to provide diversionary outpatient care and potentially prevent the need for extensive and more expensive treatment in the future would benefit the individual by greatly reducing the likelihood of justice system involvement and further ensure the safety of the community.

This is also an acknowledgement that inpatient hospitalization should not be the only intervention used to treat individuals subject to the commitment process. Outpatient services with a focus on recovery need to be looked to much more frequently as an alternate pathway to treatment. In fact, the use of evidence based practices in an outpatient setting is the goal of expanding the criteria for commitment to prevent further escalation of a crisis.

## **USE OF OUTPATIENT COMMITMENT**

We recommend that the standards in the MHPA be clarified to explicitly differentiate the criteria applied to inpatient and outpatient involuntary commitment similar to what was done in Ohio. While the current MHPA permits outpatient commitment, the current “clear and present danger” criteria limit its effective use. AOT services are defined as access to an array of services available in the community - this may include a drop-in center, an Assisted Treatment Team, intensive case management, psychosocial rehabilitation etc.

Where outpatient commitment is practiced, there is a clear operational understanding of what services and supports are available in the community to treat individuals under court oversight. In short, courts make orders for commitment while mental health professionals make the clinical treatment decisions, but when done in concert, additional benefits can be realized with community services: natural supports are not removed, increased access to peer supports, integrated treatment options are available and responsive oversight to change in clinical need can be implemented. Pennsylvania has a few counties that currently exercise outpatient commitment after years of building a mutual understanding of their community mental health system capacity and the court’s obligation.

PACA MH/DS wants to underscore that this pathway or system of care is through the civil court system and that safeguards as well as education are needed to prevent the perception criminalizing people with mental illness. The current structures are effective in overseeing outpatient commitments and permit case review to guard against harm to self or others while addressing the treatment needs of the individual. This approach must also incorporate a means to have an individual hospitalized for treatment when community outpatient services have not shown to be effective.

## **SUPPORTING BEST PRACTICES**

In addition to clarifying the law, we recommend a standardized statewide training developed and administered by the Department of Human Services to improve the consistency in interpretation and implementation of the Mental Health Procedures Act (MHPA). The training should be mandatory for all involved in the commitment process and should include a robust certification protocol.

Currently each county provides training to support the legal foundations of emergency and crisis services as well as local approaches to implementation. PACA MH/DS concurs with the most recent 2016 amendment to the MHPA requiring state training materials and standards for individuals involved with crisis and commitment procedures. Although the training is mandated and a potentially broader number of individuals may be involved, no specific treatment or service options should be required in the training sessions or within the MHPA itself.

County programs do not receive sufficient resources to create all models of services. We urge that any training approved and funded accommodate various modes including online, in person training and potentially a train-the-trainer approach. This recommendation is an effort to make the training easily available to all including, but not limited to: mental health review officers, emergency doctors, first responders, police, as well as to make it cost effective.

## **INCREASING COMMUNITY RESOURCES**

Funding for community mental health services has not risen to meet demand over time. In addition to training, the funding for county programs not only needs to be maintained and preserved, new investments are needed to create a vital array of services to meet the needs of individuals with mental illness. The MHPA is one tool we have to help individuals with mental illness. Any amendments to this Act must be carefully weighed to maintain the appropriate balance between the rights of individuals who need treatment and public safety, we also must look at the human and fiscal consequences of maintaining the status quo for people who are seriously mentally ill and our Commonwealth.

In summary, people who are seriously mentally ill, face a mental health “Catch 22”, since on the one hand the law prohibits intervening early enough to help prevent them from becoming a

danger to themselves or others; and on the other hand when they do become dangerous there is limited availability of inpatient treatment services. Sometimes people become incarcerated which results in even more narrow services available which is the ultimate restriction on their civil liberties.

We hope to promote a new pathway and continuum of care where assisted outpatient treatment helps to prevent people who are seriously mentally ill, from experiencing a tragic cycle of hospitalization, incarceration, homelessness, substance abuse, violence, or suicide. Assisted Outpatient Treatment will help to both prevent inpatient hospitalization as well as provide a mechanism to help safely return individuals to the community who have been stabilized in a hospital, but clearly are not well.

With decades of use in states across the nation, a continuously growing body of research demonstrates the effectiveness of Assisted Outpatient Treatment (AOT) in improving the lives and clinical outcomes of individuals with SMI and in reducing the consequences of non-treatment on the communities in which they live. Studies consistently find that court-ordered outpatient treatment increases short-term treatment adherence, promotes long-term voluntary compliance, and reduces the incidents and/or duration of hospitalization, homelessness, arrests and incarcerations, victimization, violent episodes and other consequences of non-treatment.

Among its most compelling functions, AOT provides a humane and therapeutic alternative to the jails and prisons that for too many people have replaced hospitals as the primary institutional setting for individuals with acute and chronic psychiatric diseases. By providing stable mental health treatment on an outpatient basis, AOT provides an exit from this revolving door. AOT also eases the strain placed on family members or other primary caregivers. Forty-six states authorize state-wide AOT with New Mexico having just added AOT in March 2016 (Treatment Advocacy Center, 2017).

While PA authorizes the use of AOT, is it de facto unusable due to the current “clear and present danger” criteria. Without a functional AOT process, many of the individuals living in PA with untreated schizophrenia or bipolar disorder experience the costly and/or dangerous consequences of non-treatment including arrest, incarceration, homelessness, victimization, violence and suicide.

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