HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA
JUDICIARY COMMITTEE
TASK FORCE ON FORENSIC SCIENCES LAW PUBLIC HEARING

IN RE: HOUSE BILL 2374, AMENDMENTS TO THE MENTAL HEALTH PROCEDURES ACT

BRIDGEPORT BOROUGH HALL
COUNCIL CHAMBERS
FOURTH & MILLS STREETS
BRIDGEPORT, PENNSYLVANIA

WEDNESDAY, JULY 24, 2002, 9:18 A.M.

BEFORE:
HON. STEPHEN MAITLAND, CHAIRMAN
HON. WALLIS BROOKS
HON. LITA COHEN
HON. TIMOTHY HENNESSEY

ALSO PRESENT:
HON. JOHN FICHTER
BERYL KUHR
JANE MENDLOW
MICHAEL SCHWOYER

JEAN M. DAVIS, REPORTER
NOTARY PUBLIC

ARCHIVE REPORTING SERVICE
2336 N. Second Street (717) 234-5922
Harrisburg, PA 17110 FAX (717) 234-6190

T2002-092

I N D E X

CHAIRMAN MAITLAND: We will begin today's hearing. I'm State Representative Steve Maitland, the 91st District in Adams and Franklin Counties. Gettysburg is my home.

Joining me today are members of the House Judiciary Committee. To my left is Representative Tim Hennessey from Pottstown. To my right is Representative Lita Cohen from Conshohocken.

REPRESENTATIVE COHEN: Good enough.

CHAIRMAN MAITLAND: And our host for today's hearing, Representative Wallis Brooks from Bridgeport.

Wallis, would you like to say anything?

REPRESENTATIVE BROOKS: I'm delighted that the Judiciary Committee has decided to hold the hearing here in Bridgeport in the beautiful new Borough Hall that we are very proud of.

My area does cover Bridgeport as well as West Conshohocken, Upper Merion, including King of Prussia and the western portion of Lower Merion.

I'm thrilled that we are here in Bridgeport and that we are in the new beautiful Borough Hall. I was here last night for a meeting

and here we are again. I'm delighted that we have such a great turnout.

Thank you, Steve.

CHAIRMAN MAITLAND: Our hearing today is on House Bill 2374. The Chairman of the House Judiciary Committee, Tom Gannon, assigned this to the Task Force on Forensic Sciences. The Task Force is responsible for getting legislation into shape in order to bring it before the full committee. We have been assigned mental health bills and perhaps in the future DNA-related bills as well.

House Bill 2374 was introduced by me as the prime sponsor as the result of a constituent contact that I had in my district. A lady had contacted me because our daughter who had befriended a mentally ill young man in high school ended up being stalked by this fellow for 10 or 15 years. It's gone on for quite some time.

It was well known after a period of time that when this young man was properly taking his prescribed medication he was no threat, he didn't exhibit bizarre behavior, he didn't bother this family at all.

But he was not responsible enough to stay on his prescription medication, so he would

periodically go into this downward spiral where he would start to act bizarrely and exhibit this stalking behavior.

He became increasingly prone to be violent to the point where this family had to practically hide their daughter. It became a real concern for Christmas, for family events.

The family would be afraid when the daughter would come home this young man would be lurking at the end of the driveway waiting for her. Every time the daughter would be late, the family would worry that something happened. They would worry, did this man act up and do something violent. Any time she failed to call while she was at college or other times the family worried. This family really lived in fear.

They did have the option of pursuing a stalking prosecution against this fellow, but practically speaking that would have probably just served to aggravate his behavior more. And the law enforcement in my area doesn't have a real good track record for aggressively prosecuting stalkers until they've been through the system several times.

House Bill 2374 is an attempt to address the problem of mentally ill people that are

or could be a danger to themselves or others or a substantial danger to property, that need to be on medication and aren't responsible enough to stay on it themselves.

I really appreciate the number of people who are experts in their fields that are here to testify today. I look forward to your testimony. And I thank you interested citizens that have come out to be in attendance with us here today.

Without any further adieu, we'll ask our first testifier to come forward. And that's Dr. Kathleen Dougherty from the Pennsylvania Psychiatric Society.

Good morning.

MS. DOUGHERTY: Good morning. Thank you. My name is Kathleen Dougherty. I am a physician at Penn State University's Hershey Medical Center. I specialize in the practice of psychiatry. And today I am coming in my role as Chairman of the Government Relations Committee of the Pennsylvania Psychiatric Society, and I'm speaking on behalf of the society today. And thank you very much for this opportunity to be heard.

The members of our governing council have carefully considered this bill, and we weigh

the arguments both for and against criteria -- changing criteria for involuntarily committing people. Although we do recognize that these are difficult positions for family members of people with mental illness, we have decided that we cannot support this bill.

This bill is all about relaxing the criteria for commitment, making it easier to put people in mental hospitals against their will. Now, the obvious concern behind this legislation is that some individuals who need treatment are failing to get it or failing to get it in a timely manner, because they are refusing treatment until they reach a level of disfunction that is great enough that they meet the current involuntary commitment criteria.

In some cases, both the disinterested parties and loving family members feel that the current criteria allows both suffering and disruption that could be prevented if the criteria were relaxed. This bill, undoubtedly, does that. By casting a wider net and having easier to meet criteria, this bill would allow more people to be involuntarily hospitalized.

However, the issue for people is

basically autonomy versus the need to protect people from harm. The current commitment statute in Pennsylvania, while it is not perfect, strikes a good balance between these two competing interests. The flaws in the current system are inherent in the tension between those two values, between the right to liberty and the need to protect people from harm. House Bill 2374 doesn't altar that basic tension.

Let me point out first that there is no perfect commitment statute. We are always going to either miss some people who need treatment or we are going to include some people who don't.

When a statute is fairly strict, because statutes by their nature are open to interpretation, the criteria can still be bent. When criteria for commitment are looser, the criteria can be bent even further and sometimes bent too far, potentially leading to abilities to abuse the criteria.

Criteria for involuntary commitment should reflect a true need to deprive an individual from liberty, not just a desire to impose an arbitrary standard of behavior on another person. We need to remember that involuntary confinement in a hospital is not a minor situation, even when it is

done out of genuine concern for a patient's well-being.

The stigma of admission, unfortunately, is still substantial. Confidentiality is not complete. The state police must be notified, and that results in losses of other freedoms that Americans have, such as the right to own a firearm. There are financial ramifications with loss of income, and sometimes direct treatment costs have to be paid because some insurance plans do not cover involuntary admissions.

This bill focuses on treating a person's illness. What we hope you will do, however, is look at focusing on the person who has the illness. We need to think about people who have chronic mental illnesses, particularly the ones most commonly committed, which are people with schizophrenia or bipolar, both of which are chronic conditions.

People who suffer from these conditions have to work at making a life despite the illness. They need autonomy and power in their own lives, and they cannot be constantly looking over their shoulders for people who are monitoring their behavior and have the ability to put them in the

hospital. This makes their lives more difficult than they already are.

I don't believe the focus here actually is the goal to just put people in the hospital; it is to have them get treatment, although this bill is about involuntary commitment.

A better approach to this problem is to adequately fund the mental health system, to end insurance discrimination against the mentally ill, to foster the use of supports and treatment relationships that enable people with mental illness to make good decisions about their lives.

Short-term involuntary commitment is a disruptive situation to the extent that families will be participating in this. It drives patients who have been committed away from their family, fosters mistrust, and fosters disruption in their life which is the opposite affect of what you want with this.

One of the bill's flaws is its failure to understand that there are reasons why people may stop taking medication. And these reasons can be very appropriate. However, the way this bill is structured, the failure to take a prescribed medication does not mean that one has lost the

ability to make a rational treatment decision.

I gave you an example in my written testimony which I would like to review with you. An example of a man who has bipolar illness which is where people have both high and low moods. The high moods are often called mania.

Let's take a man with bipolar illness who has a history of mania who has stopped taking his medications several months ago but is working and seems to be doing well. He purchases a luxury automobile that costs a fair amount of money. They can afford it, but his wife doesn't want it and doesn't think they need it.

Does this expenditure actually represent mania and the reckless spending that sometimes accompanies that? Is it an early sign of predictable deterioration into a condition that will result in serious debilitation if he doesn't return to his medication? Or does this man just want a nice car?

Under the proposed commitment criteria, he could be placed in the hospital for this action. Current laws allow people to make these choices and other choices about their lives to the extent possible. And it recognizes that

involuntary hospitalization, while it may be necessary and appropriate and at times the most humane choice, should be used only as a last resort when danger, as it is commonly understood, is present.

If an effective solution to the problem of providing treatment exists, it lies in making treatment available to individuals in a manner that provides continuity of care across the spectrum of their illness, in the preliminary deterioration phase and the acute phase of the illness in partial remission and in full remission. It does not lay in broadening the criteria for involuntary commitment which only provides a short-term fix and creates the potential for abuse.

Thank you.

CHAIRMAN MAITLAND: Thank you, Dr. Dougherty.

I would like to note that we have been joined by our colleague John Fichter who is sitting in the back of the room there. John, welcome.

Do any of the committee members have any questions?

Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you,

Mr. Chairman.

CHAIRMAN MAITLAND: You're welcome.

REPRESENTATIVE HENNESSEY: Dr. Dougherty, toward the end of your testimony you indicated there were understandable or legitimate reasons as to why people choose not to take their medicine. I can understand if they can't afford the medicine. That's a sad situation that sometimes exists. It just seems to me that there are many other times that people make an inappropriate decision to move away from medication that has been prescribed by someone who has a degree and presumably knows what's needed to correct the condition.

How do we find some way to distinguish those two different situations and make the person who needs medication and who will benefit from medication without any adverse side effects take the medicine?

I think we've all seen, anybody who has been involved in the court system for over a number of years has seen, situations where people, you know, they take the medicine because it makes them feel better. Once they feel better, then they stop taking the medicine and then they get worse and

then the cycle repeats itself.

If we can find a way -- and I think what the bill intends to do is to create a situation where medication is required, so long as it would prevent the predictable deterioration of the person's condition. It seems to me it would be common sense to try to avoid that cycle and smooth out the road for both the patient and anybody else who could be a victim.

MS. DOUGHERTY: Actually, what the bill does is allow somebody to be involuntarily committed for a short-term if they stop their medication, which is not the same thing as encouraging continuity of the medication after they leave, which is the issue that we always are confronted with. People tend not to stop their medicines in the hospital. They stop them after they leave.

And that's one of the concerns that we have about this bill. It's putting people into the hospital and then disrupting their relationships with their support givers, their family, their friends, who were concerned enough about them to put them in the hospital in the first place.

REPRESENTATIVE HENNESSEY: Well, if

those people put them in the hospital in the first place, why would we worry that it's disrupting the relationship by putting them back in the hospital if it gets them back on medication and smooths out their life?

MS. DOUGHERTY: Well, medication can take weeks or months to work and you can stop it at any time. So you can be back on your medication -- you are discharged now, you are no longer committable. Now you're mad at your family because they put you in.

I've seen many cases of patients who move away from their family because they say I'm not going to live around these people. They keep monitoring what I'm doing. They can try and stick me in the hospital all the time. I'm going to go somewhere else.

Now you have a patient who has left, who has gone away from their family, who doesn't have any encouragement to take their medication. There are outpatient programs that are in existence that are poorly funded.

It would be better if they were funded more where people go out to the home, where they monitor medication. Intensive case managers are

provided for people, particularly people who are at risk for stopping their medications, where managers can go out to the home and make sure they are taking their medication, talk to them. They stay in the home, they stay in their circumstances with their families around, they continue with their usual treating psychiatrist and therapist, and have continuity of care.

That seems more effective at preventing relapse than hospitalizing somebody briefly because they stopped their medication and they may deteriorate.

REPRESENTATIVE HENNESSEY: Thank you.

MS. DOUGHERTY: You're welcome.

CHAIRMAN MAITLAND: Representative Brooks.

REPRESENTATIVE BROOKS: I guess my question pertains to if an individual is suffering from this kind of situation and they are on medication and they stop the medication, I would assume that family members caring about the individual, noticing perhaps a personality change or a behavioral change in conjunction with the stopping of the medicine, would then report the individual.

Is that sort of the usual situation

here?

MS. DOUGHERTY: That is frequent. Although, I have to point out that families don't necessary know if people are taking medications or not. And people can have changes and deterioration when they are taking medications.

The medicines are not always effective for everybody. I have seen patients who I believe faithfully are taking their medications who still have a relapse.

REPRESENTATIVE BROOKS: For the most part, do the families have well intentions when they report that the person has stopped taking the medicine?

MS. DOUGHERTY: No. Families are not always well intentioned. That is the best -- in the best of worlds they are.

REPRESENTATIVE BROOKS: Okay.

MS. DOUGHERTY: I actually wrote an example in my testimony that I had a case where there was a couple who would take turns committing each other as part of their domestic arguments. They would write up a petition swearing that the person had done this, that, or the other thing.

And there are many dysfunctional

families where people will use the mental health system for revenge.

REPRESENTATIVE BROOKS: That's the exception, wouldn't you say?

MS. DOUGHERTY: I wouldn't -- I'd say it's a substantial minority.

REPRESENTATIVE BROOKS: Thank you.

MS. DOUGHERTY: You're welcome.

CHAIRMAN MAITLAND: I just have a couple comments.

MS. DOUGHERTY: Okay.

CHAIRMAN MAITLAND: One is that in Section 104 of the proposal here, we are seeking to provide treatment that will maintain recovery. I think it's important that we're putting the word maintain into the act because it's not there now.

Also, treatment on a voluntary basis shall be preferable to involuntary treatment. And in every case the least restrictions consistent with adequate treatment shall be employed. So the judges must consider that.

And finally, there's the language in here, before someone can be recommitted to the hospital for not taking their medication, a judge has to consider the totality of circumstances,

another phrase that would be new to the act if this bill were passed.

So a judge is going to make a decision whether or not the person needs to be sent back to the hospital under the Mental Health Procedures Act if this law should be changed. So the person has an opportunity to argue that they just want a nice car, for example. They are not going to be automatically thrown back into Norristown State Hospital, or what have you, under this law if it should be enacted.

Do you have any response?

MS. DOUGHERTY: Yes. The judges have the opportunity now to interpret the current statute either broadly or narrowly. And there is a wide variation across Pennsylvania as to what actions will get you committed.

There are actions that in some counties you will be put in, other counties would not even consider those. The nature of the statute is that it can be interpreted.

Our concern is that by broadening the criteria, as is done here, it gives the option for greatly loosened interpretation; and normal behavior, if I can put that in quotes, can be considered committable under these statutes. It

would not be the intent of you with proposing this bill, but it could easily be the interpretation and the result.

That is our concern.

CHAIRMAN MAITLAND: Well, that's true of any statute that we could enact.

MS. DOUGHERTY: Yes, it is. Our feeling is the current statute is broad enough to encompass most situations. If there is a liberal interpretation, it would encompass the situations that people have concern and that it is primarily the interpretation of the current statute that has caused problems, not the statute itself.

CHAIRMAN MAITLAND: Does the staff have any questions?

MR. SCHWOYER: Yes, sir.

CHAIRMAN MAITLAND: Michael.

MR. SCHWOYER: Michael Schwoyer, Chief Counsel to the House Judiciary Committee.

What is the normal behavior under this -- House Bill 2374, I'm curious as to the normal behavior that would be committable.

MS. DOUGHERTY: I gave you the example of a man with mania who had stopped his medication and bought a car. That could qualify under this

statute, under two separate provisions. It could qualify under the statute of substantial damage to the property of another because the wife's joint bank account is being depleted. And one could say that his buying a car is the beginning of deterioration and he should be committed for that.

I say that, without any other evidence of mania being produced other than buying the car, it would fit the statute.

MR. SCHWOYER: Right. Doesn't the statute require, as Representative Maitland said, the judge to look at the totality of the circumstances? And that individual would have the opportunity to put the whole thing in context and say, it is not my mania that is making me do this, it's this and this and that and that.

MS. DOUGHERTY: Yes. The person would have an opportunity to say that. The wife would have an opportunity to state my husband is manic. I've known him for 20 years. This is the way he is going to be. He'll be bouncing off the walls in two weeks if you don't commit him, whether that's true or not.

MR. SCHWOYER: Thank you.

MS. MENDLOW: I'm Jane Mendlow. I'm

the Research Analyst for the Judiciary Committee. Dr. Dougherty, you mentioned that there is an extraordinary amount of variation across the state. And in those situations, where it seems to work on behalf of the treatment of individuals who truly do need some intervention, you seem to be very pleased.

Can you tell us what recommendations you might have in those counties where the interpretation of the law is much stricter and it is more difficult to intervene to find the kind of assistance that one thinks is necessary for a loving family relationship, where it's totally supportive of the individual who needs help?

MS. DOUGHERTY: That's difficult for me to say. In my own county, I have experienced a change in the mental health hearing officer from a liberal to a stringent interpreter, obviously with the same statute, with the same patients. And I have seen where a patient who would have been committed previously easily has been discharged for the same behavior.

I don't know a way to correct that. I do think that is the nature of the statute, of statutes in general, that they cannot be written so specifically that they will cover every instance.

And that, again, is my concern, that given the latitude of interpretation that exists, we are better off with the current criteria.

MS. MENDLOW: Well, one more very quick question. Does your association have some recommendations that you can submit in terms of changes in the mental health system to address those issues in terms of funding and support and the kind of services that could be made more available and changes in insurance reimbursement, etc., etc.?

MS. DOUGHERTY: It's on ongoing function of our organization to try and make improvements in those areas. We have ties with the Department of Welfare. We try to review bills. That's why I'm here today. Anything you are interested in sending to us to look at, we would be very happy to submit commentary on.

MS. MENDLOW: Thank you very much.

MS. DOUGHERTY: You're welcome.

CHAIRMAN MAITLAND: Dr. Dougherty, thank you very much for joining us this morning. We appreciate your testimony.

MS. DOUGHERTY: Thank you very much.

CHAIRMAN MAITLAND: Next we have Robert Buehner, Jr., the District Attorney of

Montour County, speaking on behalf of the Pennsylvania District Attorneys' Association.

Good morning and welcome.

MR. BUEHNER: Good morning. My name is Robert W. Buehner, Jr. I am the elected District Attorney of Montour County. I have served as the President of the Pennsylvania District Attorneys' Association in 2001, and I'm currently the President of the Pennsylvania District Attorneys' Institute. I have been an elected district attorney since 1992.

In addition to that, I have served as a mental health review officer from 1985 to the present time. Incidentally, yesterday I conducted four mental health hearings. I was scheduled to do ten today. From 1978 through 1981, I represented individuals who were subject to involuntary commitment proceedings.

In the last 17 years, I have conducted approximately 4,000 mental health commitment hearings at four different facilities in central Pennsylvania, including Geisinger Medical Center, Danville State Hospital, Bloomsburg Hospital, and Berwick Hospital, as well as a variety of outpatient settings.

I have been appointed by courts in at

least 17 different counties in Pennsylvania to conduct mental health hearings. I conduct approximately 20 to 25 hearings every month. I would point out that Montour County, where I reside and am district attorney, is an eighth-class county and I am only a part-time district attorney. Montour County is the site of Geisinger Medical Center, the largest rural hospital system in the United States, and has Danville State Hospital which is a state mental health inpatient facility.

On a personal note, I was employed at Danville State Hospital during the summers of '71 through '75. I've had numerous relatives who served as nurses in the facility. And, in fact, my own grandmother was a patient at Danville State Hospital for many years and she died there. So I am familiar with the state mental health system as a prosecutor, a former employee, a mental health review officer, and as someone whose own family has been touched by mental illness and disease.

Before I get into my comments about what I want to say about House Bill 2374, I want to comment on what I just heard from the psychiatrist. I think I want to take issue and challenge some of the things she said. I don't think -- she did not

give you a very accurate picture of things.

First of all, at any commitment hearing that is conducted, it is the testimony of a psychiatrist that takes -- that mental health review officers must rely on when they make a decision. If a psychiatrist would not testify that a person meets the commitment criteria, then that person will not be committed.

So for them to say, well, they don't like the bill, well, if they don't like it then they don't have to give their testimony in these mental health proceedings. And also, psychiatrists have the ability at any time to release an individual from an inpatient setting, even though they are subject to an involuntary inpatient commitment.

Further, although she portrays this bill as dealing with -- from her vantage point -- involuntary inpatient treatment, I would suggest to you that I think what's going to happen here if this bill becomes law is not necessarily an increase in involuntary inpatient commitments, but what you are going to see is a wider use of outpatient and partial hospitalization commitments.

Currently, we do that on a limited basis. I go to outpatient settings where people are

undergoing outpatient community therapy and we hold hearings to determine whether they still meet the criteria under present law. And in some instances they do, and in some instances they don't. And in those instances where they still do, according to the testimony of a psychiatrist that I've ordered involuntary outpatient commitment.

What I sense will happen -- and my experience tells me -- if this bill becomes law, contrary to what she told you about the increase in inpatients, I think you may see some short-term inpatients -- and I will address that shortly -- and what we will see is longer outpatient commitments.

I think that's good because people will be in their communities, in their homes, in group homes, but still be subject to involuntary outpatient commitment. That's a good thing, because it will require them to take their medicine and periodically be checked for compliance with the court order that commits them.

The other thing that we need to know is that the involuntary commitment system is staged. For example, by that I mean under the emergency provisions of Section 302, the maximum someone will be subject to commitment is 120 hours.

Then it takes a psychiatrist writing an order and filing a petition with usually a social worker for that to be considered for the next step, which is a 303 hearing where the mental health review officer becomes involved.

That period of time that a person could -- the maximum period of time one can be subject to commitment under that is 20 days. And then we next go to the 304 which is up to 90 days. And, finally, for long-term individuals who have been in the system -- usually at a state hospital or sometimes outpatients have these -- a Section 305 petition is appropriate. And that is the maximum period of 180 days.

And in many instances when the mental health review officer considers the testimony, we find that psychiatrists ask mental health review officers to make decisions for less than the maximum amount. So I thought it was important to address what she told you, because I think she didn't give you an accurate picture of what the law really is. And I think that she was focusing on purely an inpatient setting. My sense in my 20 some years in the field will tell me that this is really going to address a lot more outpatient settings than

inpatient.

Now, let me address my comments. First of all, I want to commend Representative Maitland and the co-sponsors of this bill and I appreciate the opportunity to present testimony from my variety of perspectives. House Bill 2374, if enacted, will truly be a lifesaver and a cost saver.

I'll give you examples. Under present law, a person would not be subject to involuntary commitment unless they made an overt act of suicide or self-mutilation within 30 days prior to their commitment. They would not be subject to involuntary commitment no matter how many previous suicide attempts they've made, how many times they've cut themselves in self-mutilation or if they were actively voicing suicidal thoughts.

The proposed changes in the bill will permit a person to be subject to commitment if there are one or more threats to commit suicide or if the person engaged in self-mutilation and the totality of circumstances would support a conclusion that there is either a risk of either an attempted suicide or self-mutilation.

Should we have to wait until an individual hangs themself, or takes a knife to

themselves and cut themselves severely or takes any other overt action when all the signs are pointing in that direction? Obviously, the answer is no. House Bill 2374 makes the appropriate changes.

By way of analogy, let's discuss a cardiac patient with a history of heart disease. If that cardiac patient who had previous heart attacks was showing certain symptoms of a potential heat attack such as chest pain, numbness, changes in heart rate or blood pressure, would we want to wait until that person actually has a heart attack before they would be ready for treatment or sent to a hospital? Well, the answer is no.

It is far more cost efficient and medically effective to treat someone when only the symptoms are present, rather than wait until the individual actually has the heart attack to begin treatment. However, under present law, in the mental health area, we have to wait until a person commits an overt act of suicide or self-mutilation before they are subject to some type of involuntary treatment if they refused voluntary treatment. And that is why House Bill 2374 is a lifesaver.

Another section of the bill addresses the issue of individuals who decompensate due to the

refusal to take prescribed medication for mental illness. As a mental health review officer, I have witnessed this numerous times where an individual is released from an inpatient setting on prescribed medication, and because of their inability to make rational decisions or refusal to take medication, begins to decompensate and reverts back to the active symptoms of mental illness.

Under present law, there would be no commitment unless a person actually suffers serious physical debilitation or makes an overt act of suicide or self-mutilation. Many times that is too late.

Now, it's understandable that individuals consider refusing to take their prescribed medication. Some of today's medications, despite significant advances, still have potent side effects. Also, as the doctor did testify, some people get to the point where their condition does improve greatly, dramatically, and they are so -- it's so improved that these individuals think they no longer need the medicine so they stop it.

Then this leads to a gradual and downward slide to the point where some individuals lose the capacity to make rational treatment

decisions because of their mental illness.

Under present law, a mental health review officer cannot commit an individual to treatment unless overt acts occur. Experience has shown that an individual who undergoes decompensation will require longer term hospitalization to be restored back to their baseline, so they can be returned to a community setting if they are in an inpatient setting. It is also expensive and can be life threatening.

I believe the proposal that's set forth on Page 5 of the bill, in Lines 1 through 6 inclusive, will allow for an early intervention before an individual decompensates to the point where longer term hospitalization is required. As I said, I think what will happen here is the decompensation process begins and it is recognized under this bill.

What would probably happen is a petition would be filed and a hearing would be held before a mental health officer where outpatient commitment would be directed and the person would be required to comply with taking medication. Again, medication prescribed, not by the mental health review officer, but by a licensed psychiatrist. So,

again, that's a cost saver.

Another provision in the bill adds that an individual can be shown to be a clear and present danger to others if they inflict cruelty on an animal or cause significant damage to substantial property of another.

I categorically reject the analogy of someone who goes out and buys a car is going to be subject to commitment. I could never in my own mind, reading the statute, think that if these amendments are adopted would that be so construed that if someone buys a car that I would subject them to involuntary commitment.

Again, remember that all of these proceedings require the testimony of a psychiatrist that there is a mental illness and that the criteria in the bill, if these amendments are enacted that would be contained in this bill, would be met.

We all know that some individuals engage in cruelty to animals. However, present law makes no provision for subjecting the individual to involuntary commitment for these actions. Some individuals also engage in behavior which is destructive to property.

If crisis workers and the police get

called and they go out to an apartment in the community and someone is just ripping the place up and down or is actively voicing suicidal ideation and making all kinds of threats of suicide but no overt acts, these first responders and the police are generally helpless to initiate an involuntary commitment proceeding at that point because the criteria is not met.

And what ends up -- and I'll talk about this shortly -- happening is that these individuals end up in the criminal justice system where they really don't belong. By expanding the criteria commitment as you propose in this bill, I think that's a good thing because it is an alternative to the criminal justice system and allows first responders, crisis workers, to act appropriately and initiate a proceeding where an individual is taken to a hospital where they are examined by a physician and usually a psychiatrist to determine whether the commitment criteria is met.

As I said, the alternative here is criminal arrest and criminal charges being filed. It is my belief, wearing my hat as a district attorney, that people with mental illness are better served in the civil commitment process than in the

criminal justice system. The addition of these two areas, the animal cruelty area and the damage, substantial damage, to property, are two areas appropriate for civil commitment.

Studies have shown that individuals who act in cruel ways to animals are likely to engage in serious acts, antisocial behavior toward humans as well. If their problems can be addressed through the involuntary commitment process before the situation escalates to human violence, this is a worthwhile provision.

I think it is important to address this idea of civil commitment versus criminal prosecution. I can see both sides. What your House bill addresses is a logical expansion of involuntary civil commitments to areas that are not currently covered under present law, or allow for an early intervention in the civil process before matters escalate to the point that individuals either hurt themselves or others.

The alternative is the criminal justice system, as I said. Clearly, some of the acts provided for in House Bill 2374 make individuals subject to civil commitment as well as criminal penalties under the Crimes Code.

Let's look at it. An involuntary commitment is a civil process. The goal is treatment for the individual and a return to their community setting. Civil commitments can either include hospitalization, partial hospitalization, or outpatient commitments.

The criminal justice system, correctly, has as its goal to punish and incarcerate individuals where necessary, especially for violent offenders. Individuals stay incarcerated until their sentence is concluded or until they are no longer a threat or danger. Right now, the prisons and jails across Pennsylvania are being heavily populated by individuals who suffer underlying mentally illness.

I think the study that I saw indicates that in the state prison system, approximately 19 to 20 percent of the inmates in that system are under psychotropic medication. We have seen a correlation between the downsizing of the state mental health hospitals and an increase in the mentally ill incarcerated in jails and prisons. We think this is wrong as prosecutors. By expanding the area of civil commitment, as House Bill 2374 does, it will make civil commitments an alternative to jail or

prison.

We note that the issue of mentally ill criminal offenders is a serious one and, indeed, the House of Representatives and the Department of Corrections will be addressing this issue in the future. I believe there's a conference in September.

We, as prosecutors, wholeheartedly support efforts to deter individuals from the criminal justice system through the mental health commitment process when appropriate.

I would point out to the committee that the Pennsylvania District Attorneys' Association has a strong belief and commitment for treatment for individuals who may be subject to the criminal justice system. In that light, we have strongly supported provisions and programs for the treatment of drug and alcohol abuse because it is smart and more cost efficient than incarceration. It also delves into some of the root causes of criminal activity.

Likewise, in this area, the Pennsylvania District Attorneys' Association supports treatment for the mentally ill as an alternative to the criminal justice system. This

can be achieved in large measure through House Bill 2374. In several areas, the proposed change in the bill allows individuals to be treated before they commit serious crimes and end up in the criminal justice system.

However, when individuals do commit crimes, we prosecutors cannot look the other way and allow mental illness to excuse criminal behavior. We have a duty to protect our communities and the citizens of the Commonwealth. That said, if we can have intervention in the civil commitment process before behavior escalates to criminal conduct, we are pleased to support those efforts.

At this point, I want to address a particular peeve that I have about definitions. Some like to refer to the mentally ill under treatment as consumers. As I stated at the outset, my own grandmother suffered mental illness and she was a patient at Danville State Hospital for many years. Likewise, after 17 years as a hearing officer, I am very familiar with many of the patients at Danville State Hospital and others at the other facilities where I conduct hearings.

These individuals are not consumers, they are patients. My grandmother was a patient. A

consumer is someone who goes to McDonald's and buys a hamburger. A patient is an individual who needs or requires treatment, whether they are a patient at an acute care hospital for a cardiac condition or in a mental health unit at a state or private hospital.

Mental illness is, in fact, just that, an illness. It can be treated and, many times, very successfully. To call individuals who receive treatment consumers shades the issue. It implies that all individuals who suffer from some form of mental illness can always make rational decisions about their care, in much the same way a consumer can make a rational choice about selection of food at a grocery store.

While some individuals with mental illness can clearly make rational choices as consumers, others cannot, and this bill addressed that, where those individuals do not have the capacity to make treatment decisions.

This criteria for involuntary commitment is when serious physical or mental debilitation would result within 30 days from a lack or refusal of medication; in other words, when their ability to make rational decisions regarding illness could harm an individual or other people.

I would also point out, two years ago the District Attorneys' Association adopted a resolution which called for a moratorium on the closing and downsizing of state mental hospitals. For whenever reason, the current administration still pushes its policy of downsizing or closing hospitals with dangerous results. I could spend lots of time telling you about that.

Additionally, this month the Pennsylvania District Attorneys' Association adopted a resolution opposing the specific downsizing or closure of Norristown State Hospital, because we believe that such an action will have an adverse effect on the treatment and recovery of mentally ill individuals and will further endanger citizens of the Commonwealth.

As I know, Norristown State Hospital has a forensic unit. And if this hospital closes, that forensic unit will be closed with it. That is where the mentally ill who are in the criminal justice system go for evaluation. With the loss of that facility, we will have dangerous and far-reaching results for everyone across Pennsylvania.

All in all, House Bill 2374 is a

life-saving, community-protecting, cost-effective piece of legislation that should be enacted. I have spoken to numerous professionals in the mental health field, including the first responders to mental crises, as well as psychiatrists and social workers. In fact, yesterday a large part of my discussion after our hearing was to address this bill with these individuals.

Everyone I've encountered in these fields support the concepts contained in House Bill 2374. The provisions of House Bill 2374 are consistent with the positions of district attorneys across the Commonwealth, and the Executive Committee of our association actively supports House Bill 2374.

Thank you for allowing me the opportunity to testify in favor of this important legislation.

CHAIRMAN MAITLAND: Thank you, Mr. Buehner. Are there any questions?

Representative Cohen.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

Thank you, sir. I appreciate your testimony. I think -- and I have to agree with you

-- the intent of this House bill is, indeed, noble. It will protect those that are ill. Its intent is to protect those that are mentally ill as well as society and certainly family members as well.

You used in your next to the last page the term cost-effective piece of legislation. Won't, indeed, the administration of this House bill require you to even hire more ADAs? Won't it be a burden on the court system and on the county systems and their personnel? Doesn't this bring an enormous number of people back into the, quote, system and really present a burden to society, cost to counties, to the court system?

MR. BUEHNER: No, it does not. I think it's going to be cost effective, because it would deter people who are currently incarcerated in prisons where it's expensive to house them.

I'll tell you what the warden of the Montour County Prison and the warden of the Columbia County Prison have told me. The greatest single increase in expenses they have had as a county are to pay for very costly psychotropic medications for people that are currently incarcerated in prisons. And if we can -- and they have to pay full cost because they don't -- counties don't get discounts,

big issue, separate issue, but --

REPRESENTATIVE COHEN: Very separate.

MR. BUEHNER: -- the point is that if people are taking their medicine in the community setting and not in jail, we are going to save money. I don't think you are going to see such a huge expansion of individuals.

What we're seeing is a huge -- in the civil area -- what we're seeing is a huge expansion in the criminal justice area, more ADAs if this bill doesn't get enacted, because we need to defer people from coming into the criminal justice system by having them in the civil commitment system where treatment is the main approach and not incarceration.

REPRESENTATIVE COHEN: So that when you use the term community and civil commitment area, you are including facilities such as Danville, Norristown, etc.?

MR. BUEHNER: I'm also including programs -- we have one in the Columbia/Montour/Snyder/Union called Options. It's a community-based program. People are there, they attend group therapy three days a week. I committed a number of individuals presently to that program.

They ride the bus in, they go to their programs, they meet their groups, they have medication monitoring. And when their program is done, they go back to the apartments or their group homes and they are not in any hospital.

They are not -- what is really cost inefficient is to have the cycle of a person treated, released, decompensated; and because under the present administration, the state hospitals no longer take the 303 commitments. Those commitments go to community hospitals where the per diem at Hershey or Geisinger is huge to you who sit in the General Assembly and have to pay these bills. They are charging huge amounts per day, whereas Danville State Hospital is not as costly per day as Geisinger or Hershey would be. Those people that get back into the system under the 302/303 system go to these community hospitals.

Again, if you look at the per diem rates that the state is paying versus a state hospital, you're going to find how lucrative it is. And that's why Bloomsburg Hospital and Berwick Hospital and some of these community hospitals have all added inpatient mental health beds at the same time the state is decreasing, because the

reimbursement is pretty dog gone good from the Commonwealth of Pennsylvania.

I think this is a deterrent to that.

REPRESENTATIVE COHEN: Thank you very much.

MR. BUEHNER: My pleasure, Mrs. Cohen.

CHAIRMAN MAITLAND: Representative Brooks.

REPRESENTATIVE BROOKS: I would like to thank you for your testimony here today. I think your credentials are excellent. And I am a former assist DA and, as much, I really appreciate your appearance here.

MR. BUEHNER: Thank you.

REPRESENTATIVE BROOKS: I also appreciate deeply your personal revelation about your grandmother. I think that enhanced your testimony here today, because you not only bring your professional expertise but the fact that you are caring about this situation.

MR. BUEHNER: I have said this, Representative Brooks, that my grandmother at Danville State Hospital got the most loving care any grandson would ever want their grandmother to receive while she was a patient at a state hospital.

There is no stigma attached to that. I am pleased that the Commonwealth has a facility in Danville State Hospital, and I hope it stays there for people like myself who have grandparents who need treatment. And you know because of the good people that work at Norristown in your community or at Danville State Hospital in my community, they will get world-class treatment.

Let me offer this to you. We have a federal judge in our area named Malcolm, who is one of the stalwarts in the Middle District of Pennsylvania as a federal judge. His son is a patient at Danville State Hospital. And when we had a hearing on the downsizing of the hospital, another judge testified that he sent his son to clinics all across -- including Hershey Medical Center and other places -- and the best place this man was ever treated and taken care of -- his son, I should say -- was at Danville State Hospital.

He came forward at this hearing to dispel the myth that somehow treatment at a state hospital was inferior. Actually, and frankly, I've been to all the hospitals. It is superior. I'm sure that's the case at Norristown, too, to some of what you see in the private hospitals, superior.

REPRESENTATIVE BROOKS: I also appreciate the fact that you view this bill as an alternative to placement in the criminal justice system. I have seen people in courtrooms in the criminal justice system who have to be restrained or who are not communicative or are in serious condition.

I think that I'm impressed by your concern for the individual and that he or she gets the appropriate treatment.

MR. BUEHNER: We are strongly opposed, if I can say, Representative Brooks, to the cranialization of mental illness which is what we see has been going on. One of the ways to address that is by House Bill 2374. We don't want to have to use the criminal justice system as the last means to respond to dangerous behavior.

We would like to stop it before it gets dangerous. We'd like to see individuals not be part of the criminal justice system. We'd like them to be in treatment in communities. We really support that. And I'm sure you, in your experience as a prosecutor, know what we are talking about. We, as prosecutors, have had serious crimes we have to deal with that are consuming and they need to be

addressed.

These issues with mental illness that we see really, for lack of a better way of saying it, clog up our dockets. They take a lot of time, a lot of resources. We would rather see people in communities being treated so they don't come into the criminal justice system. I'm sure your experience as a prosecutor would lead you to the same conclusion.

REPRESENTATIVE BROOKS: Well, I think that we would all like to see that, where appropriate, that the individual receives treatment that he or she requires rather than incarceration, where appropriate. I think that the thrust of your testimony here today is very beneficial in pointing that out and making the distinctions.

MR. BUEHNER: We are not looking to prosecute more people in the criminal justice system. There's enough bad actors in our communities that we need to deal with. And if we can find alternatives, so that mental illness is not becoming a criminal matter as it has been for the last few years as we've seen the downsizing of state hospitals, we would be pleased by that, as we have been with supporting drug and alcohol treatment. We

think that's, again, cost effective and efficient and it reduces the crime load.

REPRESENTATIVE BROOKS: Thank you very much for your testimony.

MR. BUEHNER: My pleasure to be in your district.

CHAIRMAN MAITLAND: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Mr. Buehner, there were a couple of times during your testimony you mentioned hospitalization, partial hospitalization and outpatient treatment.

MR. BUEHNER: That's right.

REPRESENTATIVE HENNESSEY: And hospitalization is 24 hours a day, I guess, for as many days as you need it; outpatient would either be at the hospital or in a community setting --

MR. BUEHNER: Actually, it's not in the hospital. That would be in community -- an outpatient purely is in a community setting. Now, sometimes they have buildings, you know, right next to the hospital or things like that. Many of these programs now are in communities just down the

street, so to speak.

REPRESENTATIVE HENNESSEY: I guess I'm thinking of outpatient as being someone who stops by a hospital or a setting somewhere else.

MR. BUEHNER: That's a partial hospitalization.

REPRESENTATIVE HENNESSEY: Okay.

MR. BUEHNER: That's the middle ground of the three.

REPRESENTATIVE HENNESSEY: That was the question I was about to ask.

Going on to page 3, you indicated that some of today's medications have potent side effects.

MR. BUEHNER: Yes.

REPRESENTATIVE HENNESSEY: I realize you are not a doctor, but have you had in your experience as a mental health volunteer had to deal with people who are being prescribed medication which had adverse side effects which they personally found offensive and how have you wrestled with that?

I understand the idea that we need to get people back on the right track mentally. I also think that there may be other alternatives rather than the particular medication that Dr. Smith has

decided upon. If there is an adverse side effect, how do we make a shift to a different medication or a different doctor if we had one?

MR. BUEHNER: Good question. One of the medications that is relatively new -- I'm sure the psychiatrist could address this -- is called Zyprexa. It's an antipsychotic. It's a newer breed of antipsychotic medication that's in favor presently.

My understanding is one of the side effects of that can be significant weight gain. A lot of people are very sensitive that they take medicine, they start bulking up and they don't like it so then they stop the medicine.

One of the things that these outpatient programs have, Representative Hennessey, is group sessions or individual sessions where the effects of medication are discussed in a group or individual setting, and people have an opportunity to express their concerns about the side effects with the psychiatrist or psychologist or social worker.

But as a hearing officer, I tend to tell an individual that once you leave the hospital and you're no longer subject to commitment, you're

going to have to make some choices. My recommendation is if you don't want to see me again at a hearing at some point, talk to your psychiatrist, take the medicine as prescribed. Psychiatrists are people that really have the training and expertise to do this. Please listen to them, because I think that's one of the better ways that I won't see you in this setting again. So you just try and talk to people, just a human being with compassion and care for them and, you know, just see what happens after that.

I just had a hearing yesterday for a person who was hospitalized four times in the last three months and finally decided they finally met the criteria for an involuntary commitment. And what we did is we committed them on an outpatient basis. They were discharged yesterday after the hearing for 90 days for medication compliance purposes and stabilization in that community.

REPRESENTATIVE HENNESSEY: Thank you.

MR. BUEHNER: You're welcome.

CHAIRMAN MAITLAND: I have a question.

MR. BUEHNER: Sure.

CHAIRMAN MAITLAND: You have been in this field for a long time. Are you familiar with

practitioners from other states?

MR. BUEHNER: Only to the extent that psychiatrists -- because the state hospitals have been downsizing, they have been having a difficult time obtaining psychiatrists who want to make a commitment to stay in a Norristown or Danville State Hospital because they are not certain what the future is. So we have seen psychiatrists from other states come in an interim basis. It's called locum tenens is the name in medicine for somebody, you know, a doc in a box that comes in for a couple months and leaves.

So I have seen a number of psychiatrists from all over the country come into Danville State Hospital.

CHAIRMAN MAITLAND: I was just wondering if some other states have provisions like this proposal in whole or in part, and I was wondering if you knew of any horror stories because of another state that has provisions like this? But that might not be a fair question for you.

MR. BUEHNER: Only in passing and talking to psychiatrists as we are conducting hearings and anecdotal kinds of things, but nothing that I could give you a concrete example of. But,

yes, there are those stories that are there.

CHAIRMAN MAITLAND: Thank you.

MR. BUEHNER: You're welcome. Thank you.

CHAIRMAN MAITLAND: Any questions from the staff? Jane.

MS. MENDLOW: Mr. Buehner, do you see any hopeful signs on the horizon in terms of the interplay between, let's say, our State Department of Public Welfare and the Department of Corrections in terms of understanding the relationship there between the patients and the individuals who have a mental illness and exhibiting some criminal behavior as well?

It does seem like there is so much frustration in terms of the Department of Public Welfare kind of driving, shaping, all of the policies; and yet you are speaking really looking at both systems, both the human services and the criminal justice system. I was just curious for your opinion.

MR. BUEHNER: The answer is I don't see a great deal of interplay, although I think it's starting. I think the best thing that happened to Pennsylvania was when this guy Charles Curie left.

I think he was the driving force behind some of this from my understanding. Now, he is, unfortunately, in Washington, D.C., in the federal government.

I don't think he understood the unintended consequences. I think his motives were good, but the unintended consequences of the actions where we'd see this dramatic rise of mentally ill in prisons and jail. I don't think he looked at that and thought it was his problem or that his actions or the actions of the Department of Public Welfare caused these things when, in fact, they did.

To give you -- we'll always have these situations where good intentions have unintended consequences. A great example of that in another area, if I might, is that one of the Clinton Administration policies was to make housing certificates portable. So if someone had a housing certificate in Washington, D.C., and there was public housing in Danville, those individuals could take their housing certificates and come into communities all over Pennsylvania.

Well, we've got the Crips and the Bloods in rural Montour County as a result of a good policy which was to allow people to get access to public housing. It was a wonderful, noble gesture

by the Clinton Administration. The trouble is it brought the Crips and the Bloods to rural Pennsylvania amazingly.

The same thing is going on here. Good intentions, but no one has thought it through and saw what were going to be the consequences.

Ask the wardens, ask the prison people and they'll tell you. Ask the district attorneys, we'll tell you the same thing. I don't mean to disparage the man, because I'm sure he felt he was acting in the best interest of people that are subject to mental illness, and he wanted to do the right thing for them, two different perspectives completely.

MS. MENDLOW: Thank you.

MR. BUEHNER: Yes, ma'am.

CHAIRMAN MAITLAND: Mr. Schwoyer.

MR. SCHWOYER: I just wanted to comment. You mentioned, I believe, in your testimony regarding a conference coming up in September. It's sort of on the line of what Ms. Mendlow said. The whole purpose of that conference is for the Department of Welfare and the Department of Health and the Department of Corrections and practitioners and community-based organizations to

all meet and share thoughts and ideas and work on this issue.

I believe that the origin of that conference was while Mr. Curie was still here in the Commonwealth of Pennsylvania and continued on following his departure.

MR. BUEHNER: Well, that may be. I don't know the details. But I know that this process, though, has been ongoing for a number of years to downsize and it takes to the year 2002 to look at the other side of it.

CHAIRMAN MAITLAND: Mr. Buehner, thank you very much for your testimony today.

MR. BUEHNER: Thank you.

CHAIRMAN MAITLAND: We greatly appreciate it.

MR. BUEHNER: Thank you, sir.

CHAIRMAN MAITLAND: We'll ask our stenographer if she needs a break.

Our next witness is Shelley Bishop who is the Executive Director of the Pennsylvania Mental Health Consumers' Association.

MS. BISHOP: Good morning.

CHAIRMAN MAITLAND: Welcome. Fire away.

MS. BISHOP: My name is Shelley Bishop and I am the Executive Director of the Pennsylvania Mental Health Consumers' Association.

I need to, first and foremost, kind of shake off some of the disappointment in regards to Mr. Buehner's comments on the use of our calling ourselves consumers. For years, we have had a movement of individuals who have been in recovery for mental illness.

Millions of people throughout the United States -- the use of the word consumer is incredibly empowering for individuals who are attempting to regain control of their lives. And every mental health professional would tell you that the goal of mental health treatment is for an individual to be able to regain their own psychological ability, psychosocial abilities to function in communities. It's critical that we see ourselves as individuals who have choice, who can be active players in our roles of getting well.

PMHCA was founded in 1986 by individuals who had been diagnosed with mental illness who had been in the mental health system. We are currently governed 100 percent by individuals who have mental illness. We are staffed by

individuals who have mental illness and family members.

We bring and I bring a representative voice of over 4,000 folks to you today to talk about House Bill 2374, that we see proposes a sweeping expansion of forced mental health treatment by the extension of criteria for commitment and by broadening the ability to commit people in communities.

First and foremost, I would like to let you know that individuals who have experienced forced treatment, who have experienced involuntary outpatient commitment -- and studies actually support this -- report that the fear and that experience in and of itself will actually put them in positions of avoiding getting voluntary treatment in the future for any emotional problems.

PMHCA provides advocacy for individuals who are in outpatient/inpatient commitment hearings. I want to just share an example of a hearing that our advocate attended yesterday in Cumberland County. A 60-year-old woman who had recently been released from a state hospital was put into a personal boarding home. It was their first client.

Due to what came through in a hearing, the inability -- I think the lack of training of the staff in this personal care boarding home, this woman became upset and yelled, started to yell at the staff person. The staff person locked herself in the bathroom, and subsequently commitment hearings were issued.

It became clear at the hearing that this woman did not meet the criteria for commitment based on dangerousness to herself or others or of that criteria. However, the commitment was continued. And it was continued because she was in an inappropriate placement. The woman herself at the hearing very clearly stated, it's obvious I'm not a danger to myself or others.

She remains in a hospital today, Holy Spirit Community Hospital. And because of her numerous physical ailments, she has diabetes, she has lupus, she is probably going to remain committed or stay in the system of care that is tending to her. However, there are many individuals going through this type of experience who, once they are done with it, are going to run as fast as they can from this system that put them through unnecessary proceedings such as that.

There has actually been a study done, it's an empirical study, that concluded coercive treatment arouses negative feelings in the patient, creates negative expectations about the outcomes of treatment and fails to result in a trusting relationship between patient and professionals.

There are research studies that do indicate that forced treatment confers no substantial benefits in improved outcomes. When similar legislation to this was passed in New York, a subsequent study was ordered by the Legislature. The researchers concluded, legal coercion may not play a significant role in keeping individuals in treatment.

Obviously, involuntary commitment severely infringes on a person's right to be free from governmental restraint and the right not to be confined unnecessarily.

The biggest issue I want to highlight at this point is the fact in Pennsylvania we can already do what you are proposing we do. This is obviously indicated by the 60-year-old woman yesterday who was committed.

Additionally, there is one of our members who is going to be testifying in Pittsburgh.

This gentleman is experiencing his recovery in the community. He is holding a full-time job. He is married. He's raised children. This individual in the '80s was court committed to outpatient treatment. He received prolixin injections for six years based on outpatient commitment. We can already do this.

The fact that it is not being utilized, as the psychiatrist testified, that it is not being utilized effectively in a lot of communities is no good reason to expand the act that could clearly have damaging effects on large numbers of citizens in our state.

We also feel that the legislation makes some assumptions which are heavily disputed by individuals who have experienced mental illness and are in the public system of care.

The first thing is that future behavior can be predicted. There is not only no sound scientific method to determine predictability of future behavior, but it also precludes the overall goal of our current mental health system and that is that of recovery.

It really, in my opinion, goes against the whole concept of recovery. And I am here to

tell you -- and I could line people up all day to tell you that recovery can and does happen. I need to let you know that institutions are not homes and never ever should be. I am not saying that there is not good care, but to indicate that that is the best place for people to be is just one of the most horrifying statements I have ever heard. They should never be considered homes.

That violent behavior is specifically tied to mental illness and can be treated as such. No. 1, studies -- I want to point out that studies indicate that individuals who are mentally ill and who currently are abusing substance are no more likely to have violent behavior than the average citizen.

Additionally, PMHCA feels very strongly that just because somebody has -- and this term has been used in a history of mental health treatment -- that individuals who commit criminal acts are not necessarily mentally ill. There has to be careful consideration of those types of facts. And our systems certainly should never -- and I'm talking the mental health system -- be expected to shoulder the burden of treating individuals who are acting in criminal ways, sexual predators. They

should never be expected to shoulder those burdens.

The assumption that psychotropic medications are a silver bullet -- I think has been addressed somewhat here -- and that they will control behaviors. We do have very great concerns that this type of legislation will lead to a reduction in a full array of services that are needed, treatment and rehabilitation options, and will focus the mental health system of care on the forced dispensing of medications.

Another assumption is that there are methods to objectively determine and/or judge behavior and there is adequate psychiatric treatment in place to make these determinations. The extension of the criteria for commitment in the way of adding significant damage to substantial property of another person, cruelty to animals, cannot be systemically quantified, leaving these determinations to be subjectively defined.

Again, I go back to the psychiatrist saying, that's a huge concern. The fact that somebody can make a statement or make accusations against individuals that then can be taken into consideration when taking freedom away is of serious concern. I also need to address the fact, because

it is accurate that psychiatrists play a huge role in commitment proceedings.

One of what I see is the funding failures of our current system is the lack of adequate psychiatric care, the lack of adequate psychiatric time. The average individual who is currently receiving services in the mental health system gets to see their psychiatrist for five to ten minutes every four to six weeks. This does not provide the opportunity for that individual to gain the expertise of the psychiatrist in providing information about dangerous and very difficult side effects.

It certainly does not allow the psychiatrist to be able to formulate and even establish a relationship with this individual, to be sure there are other programs and social workers and psychologists and others who are in place, human service workers, to help make those types of determinations. But, again, we really are seriously lacking an adequate mental health system in this state.

And that brings me up to my next point, that individuals are in need of involuntary, forced services. The decisions used to determine

the need for involuntary treatment are often not made based on the current Mental Health Act, and that's been evidenced.

I have to tell you, folks, so often our members are saying, we want the services, we just can't get them. That's no reason to commit them. What are we committing them to? What are we going to commit people to? We're going to commit them to the same system that's in place now and it's inadequate.

The concept of community psychiatric beds -- the fact of the matter is, is that in most communities inpatient psychiatric care is dwindling in Cumberland County. I'm from Perry County, so I'm very familiar with that area. A hospital there shut down its psychiatric ward. All of a sudden we have one hospital that's serving inpatient. And inpatient can be extremely effective, particularly when people are making medication changes, they need very short-term stabilization. They don't need to be committed to a state institution. They just need to be able to have some structure and support and care. There are also other options available that are being tested in many communities.

We held at the request of the Office

of Mental Health and Substance Abuse Services a HealthChoices behavioral health speak-out in southeastern and southwestern Pennsylvania. And this was to allow consumers to voice their opinions and experiences in regards to managed care, to mandatory managed care, as well as to mental health services.

There was one individual and he was very young, I think 19 years old. And he had been in the system for a number of years, in and out of services. And as he so aptly put it, why do we have to get so sick before we can get the services we need?

This leads to the overall opinion that our members would bring to you, and that is that our public system is adequately funded to provide the treatment and support of those with serious mental illness and could shoulder the burden of increased forced treatment. We absolutely believe that this is not going to be legislation without cost. And we would certainly propose that you take a look at putting those extra additional costs into a system of voluntary care. Folks will gain voluntary care if it's there and if it's good and if it's quality, so we ask you to do that.

I know that Senator Orie passed legislation last year proposing that that occur. I don't know where that stands, but I think that it's a good proposal.

We would also ask that you take a look at the studies that indicate that there is no significant outcomes to this type of legislation. It's not just in New York. There were also studies done, I believe, in North Carolina; and there was a Rand Institute that kind of took a look at all of the studies. We think that that's important.

We also ask you to take a look at the following what we feel could be legislative activities. Certainly, assuring that state-of-the-art treatment and rehabilitation is made available to those most in need, and that these services are implemented by qualified, well-trained staff paid at rates that value the work that they're doing.

I don't know how many of you might have been at the rally. There was a rally to try to assure that we worked at getting wages for mental health workers up to par. Currently, individuals can be paid more at their local Sheetz or McDonald's than they can in the mental health system. And from

my perspective, that doesn't equal quality care.

We believe that passing true mental health parity legislation would afford the opportunity for those who have been able to obtain recovery to seek employment and to then use private insurance to be able to sustain their recovery in the community, as opposed to them having to drop out because they can't afford medication, because they can't afford the treatment they need and go right back into the system.

Value and support the concept of self-care, self-monitoring of illness and peer support -- and this is, again, where I come back to the fact that regardless of previous testimony, there is strong evidence that individuals who call themselves consumers -- many of them call themselves survivors because they didn't have the best time in the system with care and are glad to be out -- that we are provided with the support and treatment in rehabilitation, we are then able to go on and self-monitor our illness, we are able to provide self-care, and we absolutely need to be able to depend on others who have been where we are to provide that peer support. It's critical.

Support of legislated use of

psychiatric advance directives -- and, actually, Pennsylvania Mental Health Consumers' Association along with the Mental Health Association of Pennsylvania have been drafting psychiatric advance directives legislation that we hope to bring to the Legislature this fall.

That directive allows an individual when they are in a stable psychiatric state to direct in a document their future care, so that when they perhaps cycle into a situation where they are not doing well they have a document there that will really guide their own treatment. And we think that this can be extremely effective, certainly much more effective than this type of legislation in helping individuals to not get to that point where they are not doing well and everything is out the window, that they would have this document to be able to utilize, to direct appropriate care, whether it be medication, whether it would be partial hospitalization, psychiatric rehabilitation.

And also support the Department of Public Welfare, Office of Mental Health and Substance Abuse Services in their efforts to improve accessibility to quality care for those most in need.

I can tell you that working with them, they engage consumers, they engage psychiatrists, they engage all sorts of stakeholders. I can tell you that they are doing a good job of trying to make sure that we have one of the best mental health systems in the state. And I need to say also that in many communities we have good mental health systems that are providing adequate care. We would really like to see those types of community programs and services duplicated in communities where things aren't going so well.

I want to just mention some of the efforts that OMHSAS is engaging in. They are certainly focusing right now -- and I think this is very important, it might be kind of cliche -- on the fact that services need to be provided in a culturally competent manner. If services are provided in a culturally competent manner, there is a greater likelihood that individuals will be well served, because they will be meeting these people where they live, in essence, as opposed to trying to just take a box service and a box way of providing things and saying this is it, this is all you have. I think that this is very critical.

Increasing the cooperation of local

law enforcement and mental health services by providing training for police and encouraging active partnerships with crisis intervention units. I think that that was a question that was asked and responded to. There are absolutely activities that have been occurring and continue to occur that get at that interplay.

Certainly, the DPW has been active in the types of hearings and work that you have mentioned. They also are funding efforts in communities through the National Alliance of Mentally Ill in Pennsylvania to address those issues. That's something that we certainly are well aware of in the mental health system, is that we have a problem, and I know that our current deputy secretary feels that it truly is a failing of the mental health system.

Again, we are saying from our experience as people who have used services, they really need to look at what's out there because that's the inadequacy.

Again, I mention the fact that I think we should identify, present, and promote. And they are doing that, positive outcome based programs, outreach efforts. Partial hospitalization is a nice

place to go when you first get out of the hospital, but it's not someplace you want to stay real long. There are other exceptional programs. Psychiatric rehabilitation is critical. Unfortunately, it is not well funded in the state. Intensive case management is critical.

We really need to get services out to where people are as opposed to -- especially in Montour County -- where transportation is almost impossible. At our speak-outs, we did regional dialogues last year, that is probably one of the main issues with folks is that they can't get to services.

Pennsylvania is an extremely rural state. I live in Perry County. HealthChoices has improved things, so there are now two places to get outpatient services in a very large county. That's not great. I would have to depend on the county transportation system. That is, again, not great. So programs that you can get services to the people in their communities so that we don't have to bunch them up in a state hospital or bring them to a city to live, I think that that's very important. OMHSAS is working very hard at making those programs available in this state.

Supporting statewide anti-stigma, anti-discrimination campaigns. From my perspective, that is one of the things that can keep people from getting services. It can certainly lead communities to object to having these people in our communities. So I think that their efforts and support in the work of efforts that we're involved with -- again, the Mental Health Association has taken a huge lead establishing these campaigns. I think it's very important.

Supporting the efforts of self-help, peer support and psycho-eduction for consumers. And without a doubt, OMHSAS is extremely supportive and committed to doing that.

In addition, and lastly, statewide planning activities to determine current services in communities that work and gaps/needs in services to meet those who are currently in institutions and those within communities as well.

In the southeastern part of the state, for years there have been efforts -- and I think very successful efforts -- to close state hospitals and to bring people successfully back into communities. These processes have been guided by carefully thought-out, planned efforts that have

included, again, all stakeholders, family members, community members, consumers, advocates. And those activities are now being replicated across the state in every state hospital region to really look at what is -- what do we have that's working and what do we have that's not working and what don't we have at all, and to then be able to effectively plan and move forward with services in our state that are going to serve those individuals.

Finally, the focus -- and I hope that you have heard me, and it's stated in the current Mental Health Procedures Act, is on assuring the adequate treatment to persons who are mentally ill, on assuring the availability of volunteering care and support for those who are unable to cope with the devastating symptoms of mental illness, the harsh realities of hate in our world, and piercing stigma and discrimination by a society who comes to judgment based on the latest headlines.

Thank you for the chance to share what I perceive to be a critical perspective, the perspective of those of us who understand firsthand the limitations of our current mental health system and know that you cannot legislate human behavior. As much as you want to try, we can't legislate human

behavior and we can't come up with a quick fix for the anguish that often accompanies mental illness.

CHAIRMAN MAITLAND: Thank you, Ms. Bishop. Are there any questions?

Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Thank you, Ms. Bishop. It seems to me that you testified that there were two -- you were talking about perhaps two different groups of people, and maybe there are 15 groups of people or classifications of people, but it seemed as though you were talking about people who want to cooperate and want to seek mental health treatment on an ongoing basis, perhaps in the least restrictive setting, but can't have access to it because of the transportation issues or because, you know, we don't have enough people involved, maybe insurance limitations, restrictions on their own policies.

And then there is another group of people that I think the bill addresses or seeks to address which is people who don't want to cooperate. They get treatment to a point where they feel better and then they feel better and say, what's the point of the treatment anymore, I feel fine, and then they

decompensate.

I heard you testifying about, I think, the people who want to cooperate and can't find access to the system. And I think the bill is addressing a different group of people.

And how do they bring those together?

MS. BISHOP: I guess I would say that I don't necessarily see that there are two groups of people. I see that there are human beings who are depending on circumstances, whether it's a fact that there aren't good services in communities -- you know, partial hospitalization I have to tell you that -- and for myself, who I consider myself in recovery, I use a lot of alternative methods at this point in my life. I've used medications over the years, I've been in programs.

And having members who really run the broad gamut, there are excellent programs in some communities that engage individuals actively, successfully, into services. So I would say that there are a number of those folks who you're indicating sit on this, don't want treatment, who could be actively engaged in treatment, who could engage in peer support.

Certainly, one of the things that we

see as critical is to be able to sit down with people who have been there, done that, who have perhaps are ten steps ahead in their recovery process and say, listen -- and this happens a lot -- listen, you need to understand that if you don't take your medication, this is what's going to happen and you're going to be in and out the door for years to come.

The other thing that we see on a regular basis is that individuals are actually revolving in the system until -- this is the way that we see it -- basically they are beaten down and realize they don't have any other options. They have to go to the same partial program in their community, they have to see the same psychiatrist who really -- excuse me, I'm not stereotyping psychiatrists -- doesn't have the time for me, who really doesn't sit down and talk to me.

And as like any other individual, we feel -- and we are learning differently -- that psychiatrists, they're doctors. The person who is paid $6 an hour who I see on a regular basis, I don't know that I really trust what they're going to tell me or that they really understand what I'm going through. I want to see my psychiatrist, but I

only see him five minutes every four to six weeks.

So we really believe that if there were adequate treatment, rehabilitation, and support, that full continuum of services along with psychiatric care, medication, that we could engage those folks voluntarily. There are some who are going to go back and forth, but I don't think that this legislation -- you can't legislate them to take their medication, come in and force them.

I don't think that you can -- I think that there are -- I don't know. We were debating this back there. I don't think you can necessarily force people to take medication. You can encourage them, but I don't necessarily think you can take a pill and pop it down somebody's throat. And, certainly, there are ways and methods that people can avoid medications. So I don't think that's necessarily the answer.

REPRESENTATIVE HENNESSEY: Thank you.

MS. BISHOP: Sure.

CHAIRMAN MAITLAND: Mr. Schwoyer.

MR. SCHWOYER: I'm struggling to really try to understand -- I'm surprised that I sat here, because I believe that this legislation is a good piece of legislation. I'm not a policy maker,

I'm staff. I was surprised that I agree with everything that you said. I sympathize with you and I understand where you are coming from.

This is along the lines of Representative Hennessey's questions. There are people who the treatment isn't there and it's a related issue, yet it's another issue. There are communities where it's not available. And there are people who oftentimes the side effect of the medication is believing you don't need the medication.

And what do you do for those individuals who are in exactly this situation? I just don't understand -- what I can't understand is why persons who suffer from mental illness come forward and say, we don't want anyone to be able to step in to help us before we hit rock bottom. We want to wait until we are a danger to ourselves or wait until we are a danger to others and hit rock bottom, do we want anybody to be able to come in to use the system to force treatment or force hospitalization to protect us or to protect others.

That's the thing that I just can't understand.

MS. BISHOP: I don't know the answer.

Again, we come back to human behavior. We come back to, you know, this isn't -- we aren't talking about a kidney that's not working or a heart that's not working when you take your medications and you go to the doctor and they say, well, your kidney is not working.

We're talking about an extremely broad range of human emotions. There are a number of individuals within our system who are trauma survivors, who are abuse survivors. And I think in some of those cases it comes down to trust. You don't trust anybody, and certainly you don't trust a system. And then, certainly, once you've been committed once, twice, three times, four times, you certainly don't trust them.

I don't know that there are any answers. I don't know. I had a son who died of a heroin overdose. He went through numerous courses of treatment. We did everything. We were a caring, loving family. We gave him everything. To this day I question why, why didn't it work? Why did he die?

I don't think as human beings we have that answer. And I guess, furthermore, I don't think that we can legislate people. After my son died, I was right at Representative Vance's office.

I was like, we need to put something in place. We need to change the laws. I was on the phone with Charles Curie.

The bottom line is, I don't know what would have worked, but I don't think, necessarily think, that this law is going to be the answer. I think we just have to keep trying different things with folks, we have to be caring and compassion, we have to make sure the right people are there who can help them come to those better decisions in their lives.

MR. SCHWOYER: Again, you alluded to it and you said early on in your testimony that everything in this bill is what we can already do; and then a few sentences later you said, so don't expand the law. I don't understand how basically if this is something that we can already do, then we'd be codifying current practices and that wouldn't be an expansion of the law.

MS. BISHOP: As I stated later, we have some real concerns about the broadening of the scope, about the ability for this legislation to then -- because somebody has been mean to a dog -- and, again, there's nothing that says, okay, well, this would indicate what cruelty to animals is.

These are -- you have to meet this criteria to say you have been cruel to an animal.

I agree with the psychiatrist. Our psychiatric system -- certainly not for a lot of years historically -- historically, a hysterical woman could have been institutionalized for life in a heartbeat by a husband who no longer wanted her around. That might sound like it's far-fetched and in the past, but I don't think that that's -- I don't think that the possibilities that this type of legislation could lead to that are that far-fetched.

I agree with Dr. Dougherty. I really do. I believe that we have to be sure that we aren't dismissing civil rights based on very subjective criteria and that we really have to -- I think it's our Fourteenth Amendment that guarantees us the right to live freely in communities. I think we have to guard that. And I think this legislation takes us a step beyond our doing that.

MR. SCHWOYER: Thank you.

MS. BISHOP: You're welcome.

CHAIRMAN MAITLAND: I just want to make a couple comments. You said that legislation of this type is often a response of violent or high-profile incidents. That's not the case with

me. This is a response to a family that has been stalked, it's about zero profile. I just want to repeat that.

Then down on your next point, point No. 4, the right not to be confined unnecessarily. What about the right of the family that's being terrorized by a mentally ill stalker? Don't they have the right not to be confined unnecessarily?

MS. BISHOP: Well, I would consider that if somebody is stalking, I would consider that that potentially is criminal behavior.

CHAIRMAN MAITLAND: It is potential criminal behavior.

MS. BISHOP: In that case, I think it needs to be dealt with in an extremely responsive manner. I make this statement, we feel very strongly that individuals, regardless of whether they're diagnosed with mental illness or not, really need to be able to be held responsible for actions. I know that there are times that that needs to be considered. But, certainly, in a place where there is a dangerous activity or action occurring, you would not get me or I don't think any of our members to say that this person should just be left out in the street.

They are going against the rights of that family. I think that that's absolutely a case where some intervention should occur.

CHAIRMAN MAITLAND: The root cause of the stalking was a mental illness that was controlled on the medication, and it was the release of the stalker in the community where he quit taking his medication that lead to the stalking behavior.

MS. BISHOP: Then recommit them.

CHAIRMAN MAITLAND: Okay. But unless they are a clear and present danger to themselves or others, they cannot be committed under the current law. Under the proposed House Bill 2374, then they could be. That's what I'm trying to get at.

MS. BISHOP: In this case, the way this individual was acting sounds as though he was a danger to others and had a history of that and had done that.

CHAIRMAN MAITLAND: He never actually committed a violent act. It was always the threat of violence that was the fear for the family. So unless he showed up at their door with a gun or a knife, which he never actually did, although he did show up at their door.

MS. BISHOP: I would say that we also

need to take a look at our domestic relations law, because certainly in this state and I think probably more so even in this situation, individuals who are being threatened by a spouse are put in that situation daily on a regular basis.

Again, we are talking about behavior -- you know, we can do all we want and we can try to legislate and make statutes to control that, but I don't know that it's always going to be the answer. I agree with you that people need to try to be protected as much as possible.

CHAIRMAN MAITLAND: Representative Cohen who was here earlier has chaired a domestic law task force and, unfortunately, the courts kind of cling to that and it's up to the courts to make most of those changes there.

MS. BISHOP: Right.

CHAIRMAN MAITLAND: You go on to say that it's a false premise that future behavior can be predicted. I just want to flat out state that I disagree with you. We have no better predictor of future behavior than past behavior. And in the example that led me to introduce this legislation is perfectly clear because it's a cycle, it's a pattern, and we see this all the time.

I don't know how you can assert that future behavior cannot be predicted.

MS. BISHOP: Because recovery can happen, because individuals can get better, because the whole concept of this is the way I behaved yesterday so this is going to be the way -- I just think that that is extremely dangerous to make those types of across-the-board, sweeping assumptions, that it really then becomes an indicator for anybody who has ever experienced mental illness, for anybody who has ever been on medications, but that's it.

When you're talking about stalking -- sexual predator behavior, when you're talking about -- and I'm not a psychiatrist. I don't know. I'm coming from my own perspective. When you're talking about individuals who have a history of those types of behaviors, I would say perhaps there is. And I would say perhaps they need to be dealt with in the criminal justice system.

I don't know that they are necessarily individuals who -- I don't think that stalking behavior is necessarily a symptom of mental illness. I would have to defer to a psychiatrist.

Again, we want to be very careful that we don't get bunched in -- when I say we, those of

us who have been diagnosed -- with people who are violent people or stalkers, people who are sexual predators. And I think that it's easy for our general society to jump to those conclusions.

CHAIRMAN MAITLAND: I happen to know that it's a diagnosed mental illness with the case that I'm speaking of. I don't want to generalize that stalking is a symptom of mental illness necessarily.

Your second point on page 2 that recovery from mental illness does not happen and cannot be sustained without the forced use of psychotropic medication; this bill is about a lot more than forcing medicine down people's throats. There are all kinds of treatment options out there. We're not focusing on any one over another.

Your next point that violent behavior is specifically tied to mental illness and can be treated as such; under this proposal, the judge gets to look at the totality of the circumstances. So they can look at a broad range of background history, environment, psychiatrist input and so on. It's not any one specific violent behavior necessarily.

I'll stop with that because we are

running so late. I apologize to all you folks for us getting behind schedule. That's typical with these hearings.

MS. BISHOP: Thank you so much.

CHAIRMAN MAITLAND: Mrs. Bishop, thank you very much. We appreciate your testimony today.

MS. BISHOP: Thank you again.

CHAIRMAN MAITLAND: Next up we have Mary Hurtig, Director of Policy of the Mental Health Association of Southeastern Pennsylvania.

Welcome.

MS. HURTIG: Good morning.

CHAIRMAN MAITLAND: Good morning.

MS. HURTIG: I would like to begin actually with one of the problems with the format of these hearings is that statements can be made that are inaccurate or untrue and there's no chance to rebut.

I would like to clear up a few statements by Mr. Buehner, the district attorney, which were factually inaccurate. I will begin by saying that Section 8 certificate, housing certificates cannot cross state lines, so there is some confusion there. He referred to gangs moving to his district from Washington, D.C.

Secondly, it is my understanding the Supreme Court has ruled that individuals cannot be forced to take medication. So the premise that we can enforce through outpatient or inpatient commitment a consumer, a mental health consumer, to take medication violates their constitutional rights.

And lastly, the average cost of stay in a state hospital is well over $100,000 a year, so it's not a cost-effective treatment.

Now, I would like to go back to my testimony. Thank you for the opportunity to testify. In thinking about the testimony I would be giving this morning, I was struck by how long it's been since there's been an effort to amend the Mental Health Procedures Act.

I did a web search to find out exactly when the last effort was made. I discovered it was 1995. There was one bill that would have broadened the commitment criteria, but there have been no proposals to amend the act in that way for the past seven years. I find that significant. I think I know the reason.

When you create an innovative and responsive mental health system, one that provides

choices for people and services that can be tailored to an individual consumer, you have far less need for involuntary commitment. Involuntary commitment represents a treatment failure and a system failure. We need to strive for a mental health system that minimizes such said failures. Such a system is possible. In the past five years, we have been proving that in southeastern Pennsylvania.

In 1997, there was a sea change in the way the Commonwealth delivers mental healthcare to its citizens. The sea change was the Ridge Administration's introduction of HealthChoices and the carving out of the mental health and substance abuse treatment dollars. The counties were given the opportunity to manage this money in conjunction with their annual state mental health appropriations.

This system overhaul gave the counties the opportunity to truly integrate dollars and services, and to improve and expand upon these services, both traditional and not, offering consumers choices of a variety of therapeutic relationships, effective medications, more housing possibilities, the opportunity for friendships and caring companionship, places to socialize,

employment and training programs, and relationship-based case management. When those services are available, you greatly diminish the need to resort to involuntary commitment.

For decades before the creation of HealthChoices, Pennsylvanians in need of mental healthcare struggled through a vast maze of treatment providers and payers, pushed from one system to another, referred to programs based simply on whether the programs had sufficient funding or not, put on hold or simply denied care especially if they were difficult to treat. Many lost hope of ever getting timely, skilled help; and many families looked to inpatient hospitalization as the only safe haven for their stricken loved ones.

Today, with the counties having far more discretion over how to spend behavioral health dollars and with the coordination of mental health and substance abuse funds, care can be customized to respond to the needs and wishes of the person in crisis.

The resulting community-based programs are not only far more effective than inpatient hospitalization, they are also far more cost effective. In Philadelphia, for example, the

average cost of a stay in an inpatient unit is $516 per person per day, with the average length of stay slightly more than ten days.

It is obvious that when you broaden the commitment standard, you put more people in the hospital, and you quickly drain away money that could be much better spent on services and supports in the community. In other words, you preclude the kind of system reform that has been so effective here in the southeast.

That is exactly what happened in Washington state when, in 1979, Washington's Involuntary Treatment Act was revised to make it easier to commit people with mental illnesses. In 1987, when Pennsylvania was also considering broadening its commitment law, Professor Mary Durham, then of the University of Washington, came to testify before the Pennsylvania Task Force on the Mental Health Procedures Act and the mental health system.

Referring to a five-year study she had done of the disastrous impact of the revised law in Washington, she said, and I quote, broadening involuntary commitment laws did not protect the community from dangerous people, it did not solve

problems of homelessness, it wasted precious resources and it created a dependency on the involuntary commitment system that brought people back to it again and again.

More recently, the 1999 Surgeon General's report on mental health states that the need for coercion would be reduced significantly if adequate services were readily accessible to individuals with severe mental disorders who pose a threat of danger to themselves or others.

The report also notes that involuntary and coercive treatment methods simply do not work, they can cause lasting trauma and harm, and they drive people away from mental health services. The Well-Being Project, which is a research project funded by the California Department of Mental Health, found that 47 percent of consumers interviewed had avoided mental health treatment on one or more occasions because they feared they would be involuntary committed. The figure was even higher, 55 percent, among consumers who had the personal experience of having been involuntarily committed.

In January 2000, the National Council on Disability, an independent federal agency,

mandated to make recommendations to President Bush and Congress on disability issues, published From Privileges to Rights, a report which included the following recommendation:

I quote, laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy.

With the weight of such evidence to back us up, the Mental Health Association, along with other stakeholders, including consumers, psychiatrists, many mental health providers, and many family members, have to ask whether the impetus for this bill comes from counties whose mental health systems are failing the consumers who depend on them.

We would ask the committee not to move the bill forward, but instead to consider creative alternatives such as advanced directives, which Shelley just talked about. Advanced directives are

legal documents that allow people who are concerned that they may be subject to involuntary treatment in the future to express their choices about what that treatment should be.

The Pennsylvania Mental Health Consumers' Association and the Mental Health Association in Pennsylvania have been addressing this issue over the past year, with the goal of introducing an advance directive bill in the coming term. A method whereby someone can decide for themself, during a period of stability, what they want to happen should their illness cycle out of control is far better than committing someone voluntarily, which has been proven not only ineffective but to actually drive people away from treatment.

Clearly, the solution to the heartbreaking problems of individuals with severe mental illnesses is to provide appropriate services and supports so that there won't be a need to commit them against their will.

Thank you.

CHAIRMAN MAITLAND: Thank you, Ms. Hurtig. Are there any questions?

Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

CHAIRMAN MAITLAND: You're welcome.

REPRESENTATIVE HENNESSEY: Thank you, Mary.

MS. HURTIG: Sure.

REPRESENTATIVE HENNESSEY: I'm a little confused because I'm looking on page 6 of your testimony toward the bottom, laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination.

A person who needs medication to achieve a level so that he's capable of functioning in society and then feels good enough that he decides voluntarily to stop taking the medication in a sense makes a self-determination that allows himself to be compensated.

MS. HURTIG: That's where an advance directive comes in, it is exactly that person. That person while on medication, when he's not delusional, has now committed in a formal document, should I become delusional again, should I

decompensate, should family, friends, providers make this determination, this is what I want to happen.

And that document, that bill the Pennsylvania Mental Health Consumers' Association is working on is very specific; what medications, what hospital should I go to, who should be my power of attorney, what doctors, and where I don't want to go and what medications I don't want.

REPRESENTATIVE HENNESSEY: In a sense then, an involuntary system or a decision made by someone else who decides what that person -- in a way which is parallel to what that person directed in an advance directive really in your -- I guess in your terminology would not become an involuntary commitment but a voluntary commitment, because the judge would simply be ordering what the guy decided he would do in the first place and --

MS. HURTIG: It's not coercive, it's not combative, it doesn't break a trust.

REPRESENTATIVE HENNESSEY: Now, what happens -- well, it doesn't break a trust because in the sense you are doing what the person already said he wanted to have done. But at the time that he is being treated, or being put back into the inpatient or outpatient setting, he's not agreeable to that.

It's just something we've done in necessity -- I don't want to say trap, but we got him to sign something that said this would be a good idea in the future, even when at that point I won't agree with it.

I don't know. It seems to me like we're splitting hairs if the judge then decides --

MS. HERTIG: But the --

REPRESENTATIVE HENNESSEY: Hold on a second. If the judge decides in a way which happens to be consistent with what that person wrote in an advanced directive, whether the judge knew about that or not, then we would say, well, it's involuntary in the sense the judge made an order, but we'll call it voluntary because it just happens to be coincidentally the same as the guy said in the terms of his advanced directive.

On the other hand, if it slightly differs, then we'll say it's involuntary and we don't like that.

And I guess the question for me that pops up is if Tim Hennessey writes an advanced directive and yet the doctors who are treating me say, you know, the advanced directive simply wouldn't benefit him, the question should pop up,

where does Hennessey get the expertise to say what medicines he should be allowed to take and what medicines he should not be forced to take, what hospital should he go to, what doctor should he go to, and at whose expense. Should Tim Hennessey be allowed to say, I want to go to Dr. Manfrady who happens to be charging $400 an hour and not to Dr. Smith who charges $50 an hour? Who's going to pick up the tab because I chose the most expensive doctor and anything else is involuntary?

MS. HURTIG: I think you'll find that the alternative you are suggesting to Dr. Smith -- recovery and coming out of a mental health crisis and getting somebody back to a stable point involves trust. When we involuntarily -- as each study has shown -- commit people, we do damage. Part of recovery -- a huge part of recovery -- is trust, is relationship building.

REPRESENTATIVE HENNESSEY: When you say when we commit people involuntary we damage trust relationships, commit them in what sense? Commit them to a hospital where they are forced to stay twenty-four/seven, commit them to an outpatient program?

MS. HURTIG: You can commit somebody

to an outpatient program right now. We don't need to change the law. Today and every day, we are committing people to outpatient treatment. We don't need to revise this specifically.

REPRESENTATIVE HENNESSEY: The difference that I see in the proposed bill which amends the existing act is to allow for the intervention to take place at a sooner point on that time spectrum, not wait until some act happens of either self-destruction or --

MS. HURTIG: I think you're missing the bulk of my testimony. The bulk of my testimony told you that since we've created a more innovative and responsive system, that we've seen a huge diminution of people needing involuntary mental health commitments because we have created a system that permits, for example, your example.

First of all, that person writing an advanced directive in his stable state on his medication, acknowledging past misdeeds and knowing the stats of this person when he was healthy, but at the point that somebody is not delusional, building trusting relationships with case managers, friendships, etc., those interventions are far better and you will see success.

I don't know what you expect to get from this arbitrary and -- that's not the word I'm thinking of -- adversary relationship that is involved in these commitments. We try not to do them, we try our best not to do them because they are damaging. They don't get us what we think they are going to get us.

Are we expecting some type of magic that when you commit somebody to a hospital or as an outpatient, that's going to make them be nondelusional, that's going to make them cooperative, that's going to make them start on the road to recovery? You will not find consumers that will attest to that.

What does bring people to the road to recovery to stay stable, to stay on their medications, is the kind of services that you need to have in communities so that people don't take the road less desired, the road less desired.

REPRESENTATIVE HENNESSEY: You talked about involuntary commitment representing a treatment failure and a system failure even in the southeast. It would seem to me that there must be people -- or there may be people in the southeast who despite the fact that they have a wide menu of

choices available, still decompensate.

MS. HURTIG: That's correct.

REPRESENTATIVE HENNESSEY: If this bill -- it would seem to me that this bill would be tailor made for people in that situation. And if we don't have it, then we just let them spiral downward until they do something really bad, and then we face the choice of putting them in the criminal justice system, or they sit and get no mental health treatment, or try to find a way to divert them into the mental health system or maybe they --

MS. HURTIG: These people are known in the mental health system. You don't suddenly decompensate. These people are known to the mental health system. Your example, Mike's example, are known to the mental health system.

REPRESENTATIVE HENNESSEY: This didn't help them?

MS. HURTIG: No, because when they are a danger to self or others or they have intensive case management, the people who are tracking them -- and some of them have two-to-one case managers if they are intensely recalcitrant, difficult to treat, and this is a tiny minority of people with mental illness. But in that case, they are very well

known, their behaviors are very well known. Advanced directives will be very helpful in those perhaps small moments of lucidity.

These are people who get to the point of being involuntarily committed because we really don't know what to do. There is no combinations of medications that have worked. A tiny percentage of people are at that point. For most people, if you build a system with enough supports, people are maintained. It doesn't mean it doesn't happen. It does happen. It's tragic when it does happen. It's heartbreaking.

Nobody will tell you -- most folks in southeastern Pennsylvania believe that the commitment law as written is plenty broad enough to commit those people we need to commit. And we do it, and we do it every day, and we do it in the tens and the dozens. We do it because the criteria is broad enough today.

You don't need to expand it.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN MAITLAND: Mike.

MR. SCHWOYER: Mary, when I read through Representative Maitland's bill -- I was a prosecutor for ten years. I would get the phone

calls from the police department and family members, and I actually became friends with an awful lot of family members of persons suffering with serious mental illness -- this reads like their stories when they call me. And the response, like Representative Maitland said, from the police department down in Adams County is, I can't do anything yet. We can't do anything yet in the civil system or the justice system. Hang in there and wait. Wait for --

MS. HURTIG: Call the mental health crisis team and have them come out. That would be my answer. There are mental health interventions which we should and must use. They don't exist in every county and they can. The funding is there now. It's a -- we have to look to make our county systems the responsive systems we want.

The police department would call the crisis team because he is crazy. He's out there and he's brandishing a knife. He's just calling out obscenities and being a public nuisance. You could arrest him.

The other thing that's being investigated in Philadelphia is mental health court, so that a lot of people you were dealing with in those years as a prosecutor would now be people who

-- should they be arrested for public nuisance crimes and go to mental health court? And the result of mental health court can be an ordered session of treatment. They violate it, they will go to jail.

It's a far better way to go.

MR. SCHWOYER: I know I shouldn't speak for Representative Maitland, but, I mean, part of the purpose of the bill was to avoid the involvement of the criminal justice system.

MS. HURTIG: That's why you have mental health interventions. You have crisis teams, you have intensive case managers, you have peer support programs that reach out. You have places where some of the people that you were dealing with get into these behaviors because they have nowhere to go. They aren't consumer drop-in centers. Programs close down at 5 o'clock. What am I going to do from 6 on? Consumer drop-in centers run until 10 o'clock at night. They're open on Christmas. They're open on New Year's.

MR. SCHWOYER: Everything that you say sounds wonderful -- I'm not familiar with the details -- it sounds wonderful. I don't understand why not that, plus this. If those things are all in

place why --

MS. HURTIG: Because why would we broaden the law to be abused in counties where the system may not be working rather than hold the system accountable?

What we want to do is make sure that all the counties have a good mental health system. And because broadening the law means abusing the law. The psychiatrist this morning, I think, said that. The law is sufficient right now to cover the need for inpatient and outpatient commitments. It need not be broadened beyond where it is today.

Where you have troubling behaviors like cruelty to animals, like trashing the apartment, this person has cycled out of control and is now trashing their apartment. It's not somebody else's property, you can't arrest them. But we sure can send a crisis team. And where you have a good crisis team, you usually have a consumer along, too, who is skilled in sort of talk down and the befriending of. It should never even get there.

Perhaps that person in the ideal system also has an advanced directive, and also has a buddy. This is not the committee that wants to look at comprehensive mental health systems nor

should it. But when you have an effective system, your need for anything broader that's in there is obsolete, not to say it's also an infringement on people's rights.

I think we have to get back to keeping our eye on the prize, which is you want a wonderful system that responds to people before they ever get to this situation. Broadening the criteria, quite logically, means more people in inpatient settings which drains the money from counties who pay those bills, and then you'll never create the kind of intervention I'm talking about.

MR. SCHWOYER: Thank you.

CHAIRMAN MAITLAND: Representative Brooks.

REPRESENTATIVE BROOKS: I believe the majority -- correct me if I'm wrong -- of your testimony pertains to the present system?

MS. HERTIG: Correct.

REPRESENTATIVE BROOKS: You want to stay with it with slight modifications. Of course, we have administrators here, representatives, lawyers, whatever.

What I'm particularly moved by here as I go through these papers are letters from

individuals whose son or daughter or wife, the system didn't work. And they are pleading -- these letters are pleading for a change in the law.

MS. HURTIG: Representative Brooks, I would caution you for a second. We don't know whether they ever engaged the system.

REPRESENTATIVE BROOKS: Apparently from the letters -- and I don't know if you ever saw these letters -- they did. It does indicate that there were journeys through the system and for whatever reason the system didn't work. They weren't able to get them committed and the ramifications were very serious.

With this in mind, and the fact that we have first-person indications that the system didn't work, I don't know why we would not look for changes. If we have these individuals and their heartfelt letters here describing terrible tragedies with respect to their own families where the system failed their child or their spouse, why we would not look for a change where the whole thrust is to help people?

MS. HURTIG: I can answer that, because what I don't see are letters from consumers who have been involuntarily committed.

Disproportionately, people with mental illnesses seem to have -- I'm sorry -- seem to have sexual and physical abuse in their backgrounds. And the very nature of a coercive involuntary commitment hearkens back frequently to those early childhood traumas.

So in terms of what are we looking for? We are looking for a good outcome. And the predication that an involuntary commitment will lead to a good outcome, that is something I caution you about. There is some sort of an assumption that if we just get them committed, then they will stop and those anguishing letters -- and they are, and there are anguishing heart wrenching stories all over Pennsylvania.

Mental illness is a very difficult disorder, but it doesn't mean that committing them makes them well. And, in fact, what you don't see and should have are letters to show the negative side of having been involuntary committed. I don't argue that each instance -- these are people who suffer and are way out of control, causing trauma to others and themselves, and it's a desperate plea for help.

Even in the best of systems -- and I think Philadelphia is close -- we have people

slipping through the cracks, people who don't get the care they need. Show me any system, you'll find system failures. We work very hard to minimize the number.

REPRESENTATIVE BROOKS: Thank you.

CHAIRMAN MAITLAND: Jane.

MS. MENDLOW: Ms. Hurtig, in your testimony you do indicate, and I think Representative Hennessey pointed to this line, I was just going to ask if you could clarify something.

MS. HURTIG: Sure.

MS. MENDLOW: You cite this statement in a report to Congress. It was a report, I guess, by the National Council on Disability. It starts out by saying the laws that allow the use of involuntary treatment such as forced drugging. I'm just going to stop right there.

Can you point to the section in House Bill 2374 to show us where in this proposal there is forced drugging?

MS. HURTIG: No. I was referring generally to any kind of forced treatment. This is simply to amplify that involuntary commitment, coercive treatment doesn't have happy outcomes.

MS. MENDLOW: You have repeated that

point, and I was wondering if you also have empirical evidence to show whether it has been very effective and if there has been a positive outcome.

MS. HURTIG: Forced coercive treatment?

MS. MENDLOW: I would not call it that. I would call it involuntary commitment.

MS. HURTIG: Has had positive outcomes? I'm not aware of a study that has shown that.

MS. MENDLOW: Thank you.

MS. HURTIG: If you do, I would love to see it.

MS. MENDLOW: Thank you, Ms. Hurtig.

MS. HURTIG: You're welcome.

CHAIRMAN MAITLAND: Thank you, Ms. Hurtig. I appreciate your testimony this morning.

MS. HURTIG: Thank you.

CHAIRMAN MAITLAND: Next we will invite Mr. Lester Varano to come forward, please. When Mr. Varano heard I introduced this bill, he wanted to speak.

I appreciate you coming down from Luzerne County, sir.

MR. VARANO: Good morning.

CHAIRMAN MAITLAND: Good morning.

MR. VARANO: First, what qualifies me to sit at this table and to testify before you, I'm going to answer that question.

My wife Mary and I were married in 1943. Two years later, we had our first child. I happened to be overseas. I was serving with the United States Army during World War II.

CHAIRMAN MAITLAND: Mr. Varano, could you get closer to the microphone?

MR. VARANO: Sure. It was 1945 when our child was born. I was overseas at the time. When I was discharged in January of '46, our daughter was seven months old and my wife was depressed. Today they call it postpartum. In 1946, there was no name for it.

So we went to our family doctor because we were in Shamokin which is in Northumberland County. They had no psychiatrists in that town. I would not have known what to do at the age of 25, I guess. So he gave her B-12 complex and somehow she recovered.

In 1952, she had another incident that occurred. At that time, we were up to four children. She attempted to commit suicide by

drinking out of a bottle of ammonia. She didn't get any ammonia into her throat or her stomach. They pumped her stomach and found nothing there, but all of the tissue was eaten off of her tongue and the roof of her mouth. She lived on milk for a couple weeks.

We took her to the Allentown General Hospital and she was given electronic shock treatments. And then she had some other incidents that required electronic shock, but no more suicide attempts. Mary always cooperated, took her medicines, and went to see the professionals. She had to have electronic shock in 1966. She had 26 shock treatments scattered over about a six-month period.

I was in the room where they gave these treatments all those times, because I had to hold one hand and one leg, and they had a nurse or an assistant on the other side holding the other. The doctor would put some grease on her temples, put the little pads on, and he had a little box that looked like a transformer that I used with my train when I was a little kid. He would hold a tongue depressor. Are you ready? We nodded yes. He hit a button. Her body bounced off that table. She

turned red as a beet. She snored. They walked out and left me in the room with her for a few hours. So I know what it is to get an electronic shock treatment.

She had to have shock treatments again in 1986. But today they are sophisticated, and I wasn't in the room and they helped her. In fact, she was admitted to our psychiatric hospital on August 15th, just about a year ago. And after about 60-odd days in our psychiatric hospital, she went from bad to worse. We had to move her to Moses Taylor in Scranton and she was given shock treatments again.

In fact, she's been hospitalized three times. She had to have shock treatments in February. She is home now. She visits the professionals. She takes her medications. She's doing all right.

I'm here to support you folks today on House Bill 2374. We had a fifth child, a son, Raymond. As he was growing up, he was a fantastic athlete. He played little league baseball the two summers that he was allowed to play. The first year he made the all-star team as the third baseman in Kingston, Luzerne County. The second year he was

the pitcher, the all-star pitcher for Kingston.

Then he decided to become a musician. His older brother was doing well with music, and he thought he'd do the same thing. He didn't want to go to college. He got into music. One day before his 21st birthday, I'm sitting at our dining room table -- I'm an insurance agent and I must have been doing some of my planning, writing down names, phone numbers, etc., -- and he comes over and he kneels by me and he says, dad, dad, you've got to help me. I said, what's the matter? There's all kinds of thoughts in my head and I can't do anything about it.

Well, I was taking his mother to see a psychiatrist two city blocks away from where we live, so I called and I got him an appointment. He saw a psychiatrist. He says, I'm going to give him Thorazine, which is a drug that should control his problems. No one ever said to me, your wife is manic depressive, because that's what they called it up until about 1990 something, and no one said to me that he had schizophrenia. He was hearing voices that we don't hear. He was seeing things that we don't see. I think they call them hallucinations and delusions.

So the first time he was on Thorazine, he still played. He was a drummer and he played with the band. He went to his jobs, but after about a week he said, dad, I'm better now. I'm not taking that medicine anymore. I said, are you sure you should do that, Ray? He said, well, when I had a cold, when I got better I stopped taking medicine. Okay. So he stopped taking medicine and he decompensated.

And then I tried to talk with him. I said, Ray, we better get back on that medication. Oh, it makes me eat too much. It makes me sleep too much. It makes my arms and legs too tired, I can't play my drums. I'm not taking it. I tried repeatedly. One day he got mad at me and started to punch at me.

I called our community counseling services and they said, well, if he's punching you, you can get him committed. Come over and fill out a 302 form. I didn't know what a 302 form was, but I learned. So I got in him in a hospital involuntarily, and they kept him for 20 days. He got on medication again.

He was discharged, sent home, and we have the same story repeated a few weeks later. No

more medicine, dad. I have to keep playing with the band and I can't do it with that medicine. Ray, you are going to get sick again. Are you going to 302 me again? No, Ray, not unless you need it. Well, in a day or so he would get mad at me -- and I'd have to strip and show the psychiatrist all of the black and blue marks on my arms, on my chest. So this is what I've gone through.

He decompensated because he wouldn't take his medicine. He was an incompetent person, which I didn't believe at the time. This is my son, he can't be incompetent. We have five kids, the other four were doing great. That's what it was. He probably didn't realize what was going on. He couldn't rationalize and he couldn't understand.

They started working on this when they got rid of what they used to call the insane asylums -- by the way, I worked at Danville State for two months when I was 21 years of age before I got drafted. I knew nothing about mental illness. They just called that an insane institution, so I thought we had insane people and people who weren't insane. I didn't know that -- I didn't know who they belonged to. I just worked there for a couple of months.

Anyway, I think that what would happen if there was a change -- and I have been after this for a long time -- is we are going to improve the lifestyle of these people. They are going to have an opportunity to live in the community and maybe get rid of the stigma that you're a nut, you're a kook.

That's one of the things. That's the most important, but other things are important, too. For example, I asked our county coroner to send me a copy of how many suicides we have in the county, in the state, and in the nation. Well, a few years ago he did send me a copy. The nation has over 30 some thousand suicides every year. Most of those are committed by people with a mental illness. The state of Pennsylvania is up to about 1500 every year. Now, we have 67 counties, right? Luzerne is not the largest, but we're a big county and we have anywhere from 45 to 50. I got those statistics -- and I have a copy attached to my testimony. So maybe we can reduce some of these suicides.

The other item that I heard them talk about today is imprisonment. Luzerne County Prison holds about 450 prisoners, I believe. I'm on the Board of Directors of Community Counseling. I've

been very active. We have a legislative task force. I've been active with that. Every month we get a report. We've been running about 125 mentally ill people in our Luzerne County Prison that are getting mental help.

Our county is shy about 22 security people. The union is pushing the county commissioners to hire these 22 people. So far, the commissioners aren't doing it. We are over populated, and we do send some of our people to a few counties in the state that still have room in their prisons, and we have to pay them for keeping these prisoners. So it's going to cost us taxpayers in Luzerne County somewhere between $2 million and $7 million to either increase the number of security guards, build some more prisons or add on to the old one that we have or send these people to other counties where they have room in the prisons.

We have homeless people. I don't know how many of the homeless are mental illness, but I'm sure some are. And then according to the Treatment Advocacy Task Force, as it's called, we have 1,000 violent acts committed in our country every year, 1,000. And they're committed by untreated schizophrenics, people who are not taking their

medication.

You have all heard of the guy named Russell, the one who went from Montana to Washington, D.C., in July of 1999. He opened fire with a rifle and he killed two policemen and injured a few women. You also heard of the case where Sergi Babarin went into a library out in Salt Lake City and started shooting and killed a few people and wounded others.

And then a man by the name of Goldstein, who had a history of beating psychiatrists and workers in the hospital. He was discharged from the hospital. He was not on his medication. This lady was standing on a platform in New York. He walks over, do you have the time, young lady? As she looked at her wrist, he shoves her in the path of an oncoming subway. It killed her. New York has a Kendra Bill today because her mother and sisters pushed for a change. I don't know exactly how thorough that bill is, if it would be comparable to what you're introducing or if it would be even better.

So we have these violent acts. We have the homeless people. We have these suicides. We have overload in our prisons. And it doesn't

only hurt the person who has the illness, but it hurts the family. My wife, the brothers and sisters; there's five children in our family, they hurt when they see what's happening to their brother.

He was 20 years old when he became disabled. He is 48 years old today. But because they came out with drugs that are helpful, and the drug that he is on is Risperdal. It was approved by the FDA in 1994 in February. He was put on it in May. He is pretty good today. He cannot work, but he chauffeured me here today. He is waiting for me outside somewhere.

The boy is well because he learned. And what he learned was that he had a chemical imbalance. Finally, he heard those words and he adopted them and he takes his medicine faithfully. Because he ate a lot due to the drugs he had back in the '70s and the '80s, he went from 150 to 300 pounds. He is diabetic, so he has two illnesses to take care of.

Now, I believe that if we make a change -- and when Thornburgh was the Governor, he sent a committee around the state. They went to about 12 places. I made an appearance there at

Scranton because that was the closest place to home. It was 1986, my wife was getting electric shock treatments so I stayed close to home. They made a big thick booklet. They spent thousands of dollars. And then the bill that was introduced was shot down because it was going to cost too much money. It's costing us more money because of the prisons and the suicides and all these other things that are happening.

We talk about infringement, my son infringed upon my rights every time he poked me, every time he took a punch at me. Could I infringe upon his rights? No. They have passed other laws that I thought maybe would hurt in the beginning. I have been driving an automobile since 1939, I've had my driver's license since 1939. I didn't have to sit there and buckle up. If you noticed, it took me a few minutes longer to get here than the other people. I'm walking with a cane. I have trouble sliding into my car. I have to hook that seat belt up or I'm going to get a ticket, right? So that infringed upon my rights, but it's a good law because it has probably saved a lot of lives and avoided a lot of disabilities.

I used to ride a motorcycle when I was

in my 20s, 30s. I didn't have to wear a helmet. Now, they're fighting you people in Harrisburg to get rid of the helmets. Well, I was in the medical corps during World War II. I taught operating room techniques for two years before I went overseas, so I worked in the operating room.

I was on call every other night. Once a month somebody would come with their head split open, gray matter and blood oozing out all the cracks, into their mouth. And the surgeon that I worked with says, get the apparatus and start suctioning out all that stuff that's going down their throat or that guy is going to choke.

We couldn't operate on him. I wasn't eligible. We used to wait and put them on a plane and fly them on to Paris. I don't know what happened to them, but I can remember using the suctioning apparatus on the fellow's throat. So helmets do take away somebody's rights, but they do help. They save lives and they save people from becoming disabled.

So we have what is known as -- I'm on the Board of Directors of Community Counseling. We take care of a 90-bed hospital and we also have about 4 or 5,000 patients that get outpatient

service. We have a revolving door set up. The same patients -- not all of them, maybe 40 or 50 or 60 percent are in that. They're in and out of the hospital. Why are they going back? Two reasons. They won't stay on their medication and they won't go to see their professional. If they don't see a psychiatrist, they don't get another prescription. What do they do then? They decompensate.

I'm on a few different drugs to keep me going, one for my heart. I don't want to miss that because I don't want the ticker to stop yet. I have a job to do, not for my son, he is okay, not for my wife, she is okay. They are getting good treatment and I know what to do for them. I'm doing this for the others. Many people call me, maybe one or two different families might call me every week, because I was president of our group in Luzerne County for about seven years.

So this is how I feel about it. If you have any questions, fire away.

CHAIRMAN MAITLAND: Does anyone have any questions?

Representative Brooks.

REPRESENTATIVE BROOKS: Thank you so much for coming here today. I think you point out

that this is a very complex matter. Society is involved. People can be injured as this article here after the Utah shooting, of how innocent people on the street can be victimized, also how families are profoundly affected. It is a very complex issue, and you certainly through your testimony have brought it right to our hearts.

I thank you for being here today. I think -- you know, they often say sometimes out of bad experiences a lot of good comes. Unfortunately, there are bad experiences. And how you turned around and helped your family and are now actively working towards making the system better is highly commendable.

Thank you so much for coming. I was profoundly moved by your testimony.

MR. VARANO: Thank you very much.

CHAIRMAN MAITLAND: Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Mr. Varano, I think your son's name is Ray?

MR. VARANO: Right.

REPRESENTATIVE HENNESSEY: When he was

put on Thorazine and he had the side effects where he said his arms and legs bothered him and he felt tired and couldn't continue with his work with the band, were there any other medications aside from Thorazine that might have worked, or were there other types of Thorazine that would have had fewer side effects?

MR. VARANO: Well, they tried Prolixin, Tegretol, Moban. They tried all of them.

REPRESENTATIVE HENNESSEY: Thorazine was the only one that worked?

MR. VARANO: They wanted to try something else, but he wouldn't take it.

REPRESENTATIVE HENNESSEY: Because of the side effects?

MR. VARANO: Yeah, the side effects.

REPRESENTATIVE HENNESSEY: Is he still on Thorazine today?

MR. VARANO: No, he's on Risperdal. That's one of the newer drugs. That seems to work very well.

REPRESENTATIVE HENNESSEY: Without the side effects?

MR. VARANO: Well, he would have had side effects, but he's taking a drug called Effexor,

E-f-f-e-x-o-r. And then he takes Artane, A-r-t-a-n-e. He was on Tegretol at one time and it stiffened him up. He couldn't move his muscles. I think they put him on Benadryl to get rid of that side effect.

There are medicines that they could give him, but a lot of times, I guess, they refer to some of this tardive dyskinesia. I never knew what that was, except I remember seeing a lot of people with mental illness with their heads bobbing or their tongue sort of falling out of their mouth or making funny gyrations with their face, or maybe they'd sit down and all of a sudden you see their stomach jumping up or their leg would be jumping up from the floor.

These are the side effects that they go through. And this is why they have to get on the right medicine and they have to work with the psychiatrist and they have to work with the therapist to do that. And once they get the right medication, then the psychotherapy, which is talk therapy, is important because these are the professionals who understand what they have to tell these people to keep them on the right track so that they don't wind up in the hospital again.

I think we might have some of these going back into the hospital to get them back on their medication, but after they've done that a few times, I'm sure that they're going to learn their lesson, look, I don't want to come back here anymore. I'm going to take my medicine and stay out of the hospital.

REPRESENTATIVE HENNESSEY: So it that's kind of experience over the course of years that has led your son, Ray, to simply not make the decision to discontinue his medicine just because he feels better?

MR. VARANO: That's right. And he knows that he needs it. In fact, he asked me how long we were going to be down here today so he could bring his medicine that he has to take at noon.

REPRESENTATIVE HENNESSEY: Thank you very much. Thanks for being here.

MR. VARANO: You're welcome.

CHAIRMAN MAITLAND: Any other questions?

Jane.

MS. MENDLOW: Yes. Hi, Mr. Varano.

MR. VARANO: Hello there.

MS. MENDLOW: I just wanted to say

that Representative Blaum, who I work for, had received a letter about a year ago from Representative Yudichak, a letter you wrote to the representative, expressing many of your views and basically incorporating an attachment that in many respects parallels the legislation today. I think I had a chance to speak to you along the way as well.

And I just wanted to let you know that I will certainly get back to Representative Yudichak and let him know about your very wonderful testimony.

MR. VARANO: I'm sorry, I can't hear everything you are saying.

MS. MENDLOW: I'm sorry. I'm so soft spoken -- not all the time, at least that's not what they say at home.

MR. VARANO: That's better now.

MS. MENDLOW: Mr. Varano, you wrote a letter to Representative Yudichak about a year ago and we have your correspondence.

MR. VARANO: Right.

MS. MENDLOW: And then we spoke on the phone.

MR. VARANO: Right.

MS. MENDLOW: I know that

Representative Blaum and Representative Yudichak were very pleased that you were able to come today. I want to thank you for coming.

MR. VARANO: Thank you.

MS. MENDLOW: We'll let the representative know you made a presentation today and the points that you raised.

MR. VARANO: Thank you.

CHAIRMAN MAITLAND: Mr. Varano, I just have a couple quick questions. In your experience over a lengthy period of time with the mental health system in your community, do you believe that if this legislation had been enacted back when your son was 20 that more people would have helped in the community by it?

MR. VARANO: I think so, yes.

CHAIRMAN MAITLAND: Have you seen people that have undergone involuntary commitments ultimately achieve stability and sound health?

MR. VARANO: Yes, I have.

CHAIRMAN MAITLAND: Have you seen any cases where people that have been involuntary committed have been harmed by the process?

MR. VARANO: I don't think so, if they have to adhere to the instructions that they receive

from the psychiatrist and whomever else they are working with at the hospital.

CHAIRMAN MAITLAND: Thank you very much. It's a pleasure to meet you, having spoken to you on the phone a couple times.

MR. VARANO: Thank you.

CHAIRMAN MAITLAND: Thank you very much for your testimony.

MR. VARANO: Thank you.

CHAIRMAN MAITLAND: We will take a short break and then reconvene.

(Break.)

CHAIRMAN MAITLAND: I would like to invite Ms. Blossey Palovick to testify, please.

MS. BLOSSEY PALOVICK: Good afternoon. My name is Dr. Maureen Blossey Palovick. I am the Administrator of the Schuylkill County Mental Health/Mental Retardation Program and am here today representing the Mental Health/Mental Retardation Administrators' Association, an affiliate of the County Commissioners' Association.

I have served in my current administrator's position for the past ten and one half years. Previous to that, I served for 14 years as the MH/MR Services Coordinator for a four-county

joinder MH/MR Program in central Pennsylvania.

Throughout my 24 years of service to the mentally disabled, I have had the privilege of participating in the development of Pennsylvania's regulations regarding the provision of community based mental health services. I have always believed Pennsylvania to be a leader in protecting the right of the mentally ill to treatment and rehabilitative services in the least restrictive environment, in a community closest to their home communities.

In addition, I have always believed the mandate of the MH/MR Act to include the protection of the community at large from any activity that could be potentially dangerous due to an individual's mental illness.

Included in my professional activities has been the establishment of policies and procedures locally for the courts in carrying out the requirements of the MH/HR Act of 1966 and its amendments of 1976 and 1978, which are more commonly known as the Mental Health Procedures Act. This addressed the need for involuntary commitment or voluntary admission of individuals with serious mental illness to a treatment modality which best

met their needs within the least restrictive parameter.

I have always taken this portion of my position very seriously from the perspective of protecting individual rights of the mentally ill as well as the community's right to freedom from harm or threat of harm. I believe the MH Procedures Act has provided the vehicle that allows flexibility to meet both of these objectives.

In reviewing House Bill 2374, I have been able to visualize many instances over the years, when the current definition of clear and present danger has not worked well. Admittedly, there are instances where property damage occurs and injuries have occurred, both self-inflicted and directly towards others. Broadening of the commitment criteria in such instances may well benefit from review and change. This may be particularly so also in terms of the initial step, which is the five-day commitment which addresses emergency situations in the community.

I suggest, however, that careful attention be given to the actual language used and the danger of misinterpretation of intent in the change. I also recommend that any changes made to

the act be well defined; i.e., predictable deterioration, cruelty on an animal, significant damage to substantial property, and the capacity to make a rational treatment decision.

As currently proposed, the language places administrators, emergency service delegates and physicians in the position of predicting behaviors without adequate definition.

The proposed language is ambiguous and could be deliberately misinterpreted to predetermine a desired outcome of involuntary commitment when it is not necessarily justifiable. Cultural differences, personal preference and the individual's right to choice could easily be overlooked if terms are not specifically defined.

For example, an individual who chooses not to have open-heart surgery for personal reasons could be involuntarily committed because a physician believes his or her opinion of predictable deterioration allows the surgery to occur without the patient's consent. This request was actually presented to me by a physician in a community hospital.

Upon mental status examination, that patient was found to be making a rational decision

based on his personal religious preference, and he clearly was not mentally ill. The testimony of the treating physician, however, could have been enough with a vague interpretation of predictable deterioration.

I support the inclusion of past history as an indicator of a pattern of behavior that may be considered in an emergency involuntary commitment process. This, incidentally, does exist currently under the law for us in the extended commitments of 303 and 304, the 20 and 90 day, but is not in the initial commitment piece that we have.

The inability to present such evidence often results in the need for more serious debilitation and harmful behavior from the individual before involuntary treatment can be pursued. The allowance of evidence of a past behavioral pattern indicating a predictable outcome is a significant step forward in averting dangerous situations in many instances.

The inclusion of medication compliance or non-compliance specifically as criteria for extended treatment is very definitive and will in many instances serve as the vehicle to put involuntary outpatient commitment in place instead

of a more restrictive involuntary inpatient commitment.

Over the years, the use of involuntary outpatient commitment has diverted many people from more restrictive treatment. The removal of involuntary status has often resulted in decompensation of the individual. The primary reason for this has been discontinuance of medications, which frequently results in the individual being rehospitalized, and a repetitive cycle of stress for the individual, his or her family and neighbors. And I don't think I could stress that any more than Mr. Varano just did.

Pennsylvania has always been a leader in adhering to the premise of the least restrictive treatment in a setting closest to one's home community. This has resulted in changes in regulations and amendments of law over the last 30 some years to meet the ever-changing picture which this premise has presented to the communities of Pennsylvania.

This proposed amendment has the potential to continue this leadership, but only if it is amended to be much more specific and clear in its intent. I ask that consideration be given to

the individual's rights as well as the community's in these legal proceedings regarding mental health treatment.

Those are the statements from my formal testimony, but having sat through several this morning, there were a few other things that came to mind, too. I would hope that the panel does not misconstrue HealthChoices with the current mental health system because HealthChoices, although it has the capability to expand community-based services, is clearly a managed care of Medicaid Program and is aimed at that population, whether they are seriously mentally ill or not seriously mentally ill.

Some of the other things that came to my mind, too, while I was listening is crisis intervention and emergency services in your county programs that are out of the MH/MR Act are very, very critical in the sense that the one set of programs, whether you call it social worker or public law, whatever, it's the one area where everybody comes together to bring about a resolution to a situation.

It touches all ages of individuals. It can be a child, it can be an elderly person, it

can be a middle-aged working man, it can be a person that is seriously mentally ill and homeless on the street. It involves families, communities, the individuals themselves, and it has police departments, hospital personnel, in your smaller counties such as I've worked in, your fire departments, and so on, all working together to try to resolve a crisis in the community. It's a crisis for the individual, and it's a crisis for the community and for the family that the individual may be in.

But most importantly, I think you need to know that your system works. It does work for the majority of the people. Of the many commitments done in the small counties such as we have -- Schuylkill County is approximately 150,000 people -- we commit an average or admit not all involuntarily 53 to 60 people a month. Out of that, perhaps 12 to 15 of them are actual involuntary commitments. But I must say they are not all seriously mentally ill.

They are persons with first psychosis breaks, they are women with postpartum, such as Mr. Varano described. There are families torn apart because they don't understand what's going on, and it may never happen again because they are very

cooperative at that initial break.

So your crisis workers and your emergency people who follow the MH/MR Act and the Mental Health Procedures Act clearly do do a good job. Your county programs do a good job. It's a very difficult balancing act sometimes to protect both the community and individual rights, but we work very hard to do that.

I would ask that you please give some consideration to the assisting with a more defined term the conditions that you've laid in the bill to help us in doing that so we don't go back to days of old.

CHAIRMAN MAITLAND: Thank you, Dr. Palovick. Are there any questions.

Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

Dr. Palovick, you cited somebody who chose not to get heart surgery for his deteriorating heart condition, and then you said that ultimately it came out that everybody agreed that he had the right to make that decision.

Was he actually petitioned under the Mental Health Act before a decision like that?

MS. BLOSSEY PALOVICK: Yes, he was. I want to clarify that, too, so that you can understand the importance to me of this act itself.

This gentleman was in a local hospital and the physician that was treating him believed that he needed to have the surgery. He refused to have it. The physician petitioned saying he believed he wasn't rational because he wouldn't choose to save his life. He believed that he would die if he didn't have the surgery and he wanted the delegate, who was my staff person, to agree that he should be committed.

The delegate called me at home basically saying this man is not mentally ill. There were no signs of mental illness. He was very clear about why he was choosing that road. And his family was explaining it right along with him.

Their anger was directed at the physician. They weren't really even sure who the delegate was at that point to be very honest.

REPRESENTATIVE HENNESSEY: A petition should have been filed against him.

MS. BLOSSEY PALOVICK: Well, let's not go down that road.

REPRESENTATIVE HENNESSEY: Okay.

MS. BLOSSEY PALOVICK: We did deny the petition and that's the important part. We had the ability to do that. We can say, no, this person should not go for an examination by a psychiatrist, there is no need.

Broadening the definition without giving us --

REPRESENTATIVE HENNESSEY: You intervened before it ever got to a hearing?

MS. BLOSSEY PALOVICK: That's correct.

REPRESENTATIVE HENNESSEY: You really never started up the mental health proceeding?

MS. BLOSSEY PALOVICK: That's why it's important for me to have these definitions, too, because these definitions lead me to the community before it would ever get to a hospital for a psychiatric exam and admission to be able to use these criteria.

The criteria are not necessarily used only by a doctor.

REPRESENTATIVE HENNESSEY: We would welcome your suggestion for the, you know, additional language to provide more detail for the definition.

MS. BLOSSEY PALOVICK: Okay.

REPRESENTATIVE HENNESSEY: Because people like you who work in the field probably have a much more detailed grasp of the concepts than we do. And any suggestions you can make we would certainly welcome.

MS. BLOSSEY PALOVICK: I would be glad to have the association do that. We have bi-monthly meetings and I will bring that up. I am president of the association, so right now I will make that a task of the Mental Health Committee to begin looking at that.

The terms that I have listed in my testimony are the ones that were raised that were our concerns when we read it. We welcome looking at the 30 day, beyond the 30-day history, that is often very much held to a psychiatrist where he believed someone needed to go in. They couldn't look at something that happened maybe 40 days ago or 50 days ago and they won't bend the law. At least the ones that I know won't do that. It says in the last 30 days.

So allowing them to look at history which did happen in that '78 amendment, it allowed them to look at it when they do the extended hearings, as Mr. Buehner was talking about this

morning, where they for 90 days or for 20 more days beyond that initial commitment.

Where my staff and I get involved are where there is an emergency going on in the community right now. It may be a suicide attempt. It may be a lot of different things. The bottom line is it must meet the legal criteria set forth in the act to be able to be taken to a hospital right then and there.

It is our responsibility as designated by our judge and most county judges to have an administrator's delegate make that decision, do they get examined by a doctor or not for mental illness. And if we feel they do, they go see the doctor in the hospital and it goes from there.

REPRESENTATIVE HENNESSEY: Thank you, Dr. Palovick.

MS. BLOSSEY PALOVICK: You're welcome.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

CHAIRMAN MAITLAND: Staff, any questions?

Jane.

MS. MENDLOW: Dr. Palovick, could you give us some insight as far as your understanding of

how the proposal works in terms of a suicide threat? Do you feel that it's written tight enough so that it would not apply unless there were criteria that you felt was necessary to make sure you really identify people who are really a serious risk actually to commit suicide?

MS. BLOSSEY PALOVICK: I think the thing that this particular piece of legislation has for us would be the ability to look at someone who maybe has made threats over the last three or four months of doing something along those lines and is doing it again but maybe more seriously, and everyone is feeling that there may be an attempt at this point, or four or five times of threatening to do this in a serious way is enough to warrant us as mental health delegates looking to have a psychiatrist speak to them at least.

That's the point of our law. We don't say, you are committed. We say, you are going to see the doctor. He will decide or she will decide. I do not believe that broadening it to allow us to look at this past history in particular will harm that procedure whatsoever.

The physician has the decision to make once they are in the hospital and if they want

extended time or do not want extended time.

MS. MENDLOW: Thank you.

MS. BLOSSEY PALOVICK: You're welcome.

CHAIRMAN MAITLAND: Mike.

MR. SCHWOYER: Representative Hennessey asked if your association could work on definitions.

MS. BLOSSEY PALOVICK: Yes.

MR. SCHWOYER: I would ask that -- I'm Michael Schwoyer, chief counsel for the committee -- if you are able to do that, I would appreciate you sending them to me, and then I can see that they are distributed to the committee and that we give consideration to them.

MS. BLOSSEY PALOVICK: Fine. I will ask the association to make some recommendations to you, and then you can just pass them along.

MR. SCHWOYER: Thank you very much.

MS. BLOSSEY PALOVICK: Sure.

CHAIRMAN MAITLAND: Dr. Palovick, thank you very much for your testimony this afternoon.

MS. BLOSSEY PALOVICK: Thank you.

REPRESENTATIVE HENNESSEY: Tell your committee not to be too upset if we tinker with them

after we get them, all right?

MS. BLOSSEY PALOVICK: We know that will happen.

REPRESENTATIVE HENNESSEY: Thank you.

CHAIRMAN MAITLAND: Next we have Mr. John Stanley, Assistant Director of the Treatment Advocacy Center.

MR. STANLEY: I have written here good morning, but I guess I'll go with good afternoon. Today this committee considers a measure that would reform a law that mandated tragedy. I see these tragedies every day. I work for the Treatment Advocacy Center which is a non-profit organization that tries to reform laws that create barriers to treatment.

We have never put ourselves out as a self-help organization or a help organization, but nonetheless people hear that we are there and we get the calls, dozens of them every day, from people who love someone with a severe mental illness who has lost rationality, but for whom the law cannot help.

Before offering a broader analysis of this bill, I would like to tender a few observations that I hope will refine your consideration of it. This committee should not be in favor of HB 2374 if

it determines that medication is not vital to the treatment of someone with severe mental illness, nor should it be in favor of the bill if it finds that abuses of the system or the potential abuse of the law too great to justify its use. That's something for you to consider after hearing the testimony.

Let's get something out of the way from the start. Voluntary treatment is more preferable to involuntary treatment. But what this bill considers is what happens when voluntary treatment is not an option. Also, this bill should be considered in context. Even state laws that are much more treatment oriented than Pennsylvania is, much broader standards, is somewhat akin to what this bill suggests. In those states, the laws are only applied to a very small percentage of people with severe mental illness.

And listening to the prior testimony, I find people talking about two different groups of people. I find people talking about what happens to someone who has cognitive thoughts, is capable of making rational decisions, what can best help their recovery. And you know what, encouraging empowerment and self-determination is what should be done. But then what happens when the person loses

the ability to make rational treatment decisions? That's what you're looking at.

You will hear more services, we need more services. And those people are absolutely right. But they are put in the context of reforms like this or more services. They are not in competition. They are two different subjects. One is about how much we have in the pot. The other is about how much we have in the pot. The other is about how we dispense it. Should someone be disqualified from treatment simply because they are so overcome that they don't even know that they are sick. And there is a good percentage of people out there that don't know that they are sick.

A body of researchers emerged in the last 15 years pioneered by someone by the name of Dr. Xavier Amador, who was formally out of Columbia University who is now working for the National Alliance for the Mentally Ill. What he has discovered that was previously thought of as denial, just like, oh, no, he's not going to break up with me, that type of issue, is actually a physiological symptom of the illness. The illness affects the mind, particularly frontal lobes is what they're looking at, in such a way that the person isn't

capable of even realizing that they're sick or have some impairment at different levels going up from that.

Again, that is what this bill addresses. And what do you do with that person that can't know that they are sick. The choice, the freedom of choice, is another thing that you will hear said again. You cannot impinge on our freedom of choice. Again, that's talking about a different group of people with mental illness, the ones that have the ability to make that choice.

The question before you goes either way. The law is going to choose to do something for a certain group of people because the present law or a group decides that there will be no treatment. This law for that same group will decide we will give them treatment when they can no longer make the decision on their own.

Now to explain why Pennsylvania's law as presently done ensures tragedy, I think we first must look to the past. The framework for the treatment of people of mental illness was formed through a process of something called the institutionalization in the mid '60s and onwards. We took people out of hospitals and we put them in

the community. This is the best thing that could have ever happened to some of us with severe mental illness. One very important reason was the advent of effective medications for severe mental illnesses, like bipolar disorders and schizophrenia. All of a sudden people who before by necessity had to be kept in an inpatient facility could thrive in our communities.

And at the same time, seeing how bad things were before and seeing how good they could be, the legal standards like the one we're looking at in the bill started to change. They changed from far, far too wide, too undetermined, too overbroad, from the point where you would hear the stories -- and we heard some of them. I wouldn't be surprised if a lot of the stories that you've heard about a husband putting a wife in and everything originated from pre 1976, because those laws needed to be changed and they were. But they changed them and they have made them too strict.

They changed them to what Pennsylvania's law currently is, which basically is that there has to be some sort of immediately pending danger before anything can be done, some immediately pending harm. And so it unintentionally

codified the right to be psychotic, because we have one set of laws that said you have to be dangerous and at the same time released people from these hospitals but did not address when someone decompensates, when someone becomes irrational again.

I think we see the answer in a variety of tragedies. We see it in tragedies that affect America. We see it in 200,000 people who have severe mental illness who are homeless. That's one-third of the homeless population. We see over a quarter million people in state jails and prisons; 5,000 people with schizophrenia and manic depression take their own lives each year. And then there are those that are hurt because someone else did not get treatment.

You heard reference before to a study that the people with mental illness who do not abuse substances are not more likely to be violent than people from their communities who are also not substance abusers. That's what this study says, but the findings also have something else. The study shows that people with severe mental illness are more likely to be substance abusers and that those with mental illness who do abuse substances are more

than likely to be violent than substance abusers without mental illness.

That study does not generally show an equivalent risk of violence between those with mental illness and those without. Overall, the group with mental illness was found to be about twice as likely to become violent as the control group drawn from the surrounding community. Most other studies show an ever stronger correlation than that.

Now, let me get this straight, mental illness is not responsible for most violence in our society. Compared to the overall amount of violence in our society, this heightened propensity is small, but the difference still adds in to hundreds of Americans each year losing their lives because somebody doesn't have treatment. It's hard to come up with a precise estimate. Our center estimates that 1,000 people in America each year lose their life because there is no ability to get someone treatment when they obviously need it.

There are some solutions to this. One of the two main ones you are looking at in this bill is to widen the standard, which is what HB 2374 does. It allows a person with severe mental illness

to be placed in treatment if he or she is unable to make rational decisions along with a few other criteria on this.

Now, picture this. Someone unable to make rational decisions and serious harm would ensue within 30 days without prescribed psychotropic medication for a diagnosed condition. I ask you to think if you were so sick, so irrational and so in danger as to meet that standard, would you want help given to you? Would you want to be helped when you could no longer help yourself?

Now, I was -- well, there was some passing references to it -- very surprised not to hear the word unconstitutional come up more often this afternoon. Maybe people are starting to learn. A constant assertion of many who oppose the expansion of benevolent coercion is that the provision of treatment to someone overcome by mental illness violates the constitution absent express consent unless the person is imminently dangerous to themselves or others.

The Supreme Court never said that. As a matter of fact, the issue is unaddressed. I'm a lawyer who specializes in these laws. I have looked at all the precedence. The Supreme Court has

not made a definitive statement about that at all. Sometimes people will patch together some dicta and try to say that's what it says.

I think absent of that expressed determination, what we have to look to is what is happening. First of all, laws that would violate what is put out as must be imminent physical danger, if that is so, there are at least 20 states whose laws are violating the Constitution. And more to the point, is to look at the State Supreme Courts that have considered this. There are two.

This month, the Wisconsin Supreme Court enthusiastically endorsed as constitutional that state's fifth standard which is along the broadest treatment standards now in place in the country. The Court said the fifth standard applies to mentally ill persons whose mental illness renders them incapable of making informed medication decisions and makes it substantially probable that without treatment, disability or deterioration will result, bringing on a loss of ability to provide self-care or control thoughts or actions.

It allows the state to intervene with care and treatment before the deterioration reaches an acute stage, thereby preventing the otherwise

substantially probable and harmful loss of ability to function independently or loss of cognitive or volitional control. There is a rational basis for distinguishing between a mentally ill person who retains the capacity to make an informed decision about medication or treatment and one who lacks such capacity. The latter is helpless, by virtue of an inability to chose medication or treatment to avoid the harm associated with the deteriorating condition. I think I've heard that a few times in different words today.

The issue before this committee is not a constitutional one. It is one of proper state social and medical policy. I just want to add in, one of the members asked a question about do we have any outcome data on how involuntary treatment works. The answer is really what we have it for is for outpatient commitment because it's been studied very heavily.

And what we found there is the use of outpatient commitment for individuals -- the largest study, the most respectful study, everybody agrees on that, is something called the Duke Study which came out of North Carolina, oddly enough. And that found that the use of involuntary outpatient

commitment, if you will, reduced hospital admissions by 57 percent, and over a year it reduced the length of hospital stays by 20 days.

I'll stop there and point out that the single most expensive expense of state or county in terms of mental health is the inpatient bed. It also reduced arrests. The rearrest rate for those in assisted outpatient treatment was one-quarter, 12 percent versus 47 percent, that of the control group. They also found that violence was reduced from 48 percent to 24 percent. I think I should add that the arrest of what I gave before was actually for a subgroup of people who had a prior history of violence.

Most startling are the outcome numbers for the first 141 people placed under outpatient orders under Kendra's Law in New York's new assisted outpatient treatment law. Because of Kendra's Law, those in this program have experienced a 129 percent increase in medication compliance, a 26 percent decrease in harmful behavior, a 194 percent increase in use of case management, and a 67 percent increase in the use of medication management services.

And that which has been said by some other speakers today is key, because I haven't seen

the figures, but my impression is that outpatient orders in Pennsylvania are very rarely used. And the reason that I will point to is the standard that you look at in this bill. Because if you require immediate dangerousness in order to use an outpatient order, you ask a hearing officer or a judge or whoever is making the determination to in the same hearing find the person dangerous immediately, and which is inherent whether it's in the statute or not safe enough to put back in the community, it just doesn't happen.

Thank you.

CHAIRMAN MAITLAND: Thank you, Mr. Stanley. Are there any questions?

Representative Hennessey.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Chairman.

CHAIRMAN MAITLAND: Sure.

REPRESENTATIVE HENNESSEY: Thank you, Mr. Stanley.

MR. STANLEY: You're welcome.

REPRESENTATIVE HENNESSEY: There was some discussion earlier as to whether or not -- perhaps it's really a semantical thing -- an involuntary commitment, even partial commitment, or

to an outpatient center, whatever, does that become voluntary because the person three months or six weeks or some period of time before that signed and said this is what I want to happen?

We were given some stories, some comments by a woman who was concerned about her daughter. And she says that she wants to be forcibly medicated when she gets sick, but when she gets sick she refuses to make the medications. It seems to me that what I heard earlier from some of the speakers was that we empower the consumer, the mental health consumer, to direct their own treatment by having them sign an advanced directive and that that somehow manages, I guess, to circumvent the problem that this woman says that once my daughter gets sick she says, forget all of that. I don't want the medication.

I'm just having some difficulty trying to figure out whether or not from a patient's or consumer's point of view, whether or not once -- if I've signed that advanced directive and now I need medication and I don't want it and somebody says, you signed this paper six months ago, am I then more receptive to that treatment because now I think that it's voluntary as opposed to before I looked at that

paper and was reminded that I signed it, I was pretty darn sure that this was involuntary because some judge was ordering it and I didn't want it, I'm saying no today.

Is there a benefit? I mean, once you point out to me that sort of I've built my own scaffold here, all right, do I then feel much more comfortable by the fact that I'm going to get this treatment which I really want to refuse today?

MR. STANLEY: Well, if you're sick enough to meet the standards of this bill in that you're incapable of making a rational decision concerning your treatment, you probably wouldn't be.

Advanced directives are very complicated. There is a variety of factors. And, first of all, there has to be -- for them to really work other than in a subjective manner, other than if there's a commitment, the judge sees what I want and maybe goes along with what I said, there has to be a state statutory mechanism that makes them enforceable, which is done only in a very few states. And there has to be perimeters set on when you can set the mark on when they can take over, and normally it's incompetency.

It becomes an alternative commitment

in that case. Normally, there's some boundary that's put on it. It gets confusing when people start talking about advanced directives because they're used in every state, but it depends on what the state law is because if there's no enforcement, if there's no specific statutory mechanism for them, they're basically just a contract.

And you know what the thing is? I can't sign a contract to be forcibly medicated that I can't later just back out on if I'm of sound mind and will, because it's not a contractual obligation that can be fulfilled.

REPRESENTATIVE HENNESSEY: But I think you're missing the point of my question.

MR. STANLEY: I'm sorry.

REPRESENTATIVE HENNESSEY: You work in the treatment field.

MR. STANLEY: As a lawyer. I'm not a doctor.

REPRESENTATIVE HENNESSEY: Maybe you're not the right person to ask the question to, but you're the only guy I have here.

MR. STANLEY: I have been committed, though, if that helps. I have manic depression with psychotic tendencies. I can tell you at least when

I was in there -- look at it this way, when I was committed -- I mean, to show you the difference in the bill and the people that are axed out on here, I had psychotic thoughts, paranoid. I thought every other person was a secret agent. I would not agree to any kind of treatment because it was CIA poison, basically, to make a long story short.

I ran around New York City for 72 hours. I ended up in a Korean deli naked standing on top of a plastic milk carton, because I thought they would put these death rays in there and my wet clothes were conducting the energy. I was very lucky because the officers that responded -- I couldn't get off the milk carton because of the electrical energy -- took me to a psych ward, they didn't take me to jail.

Now, New York's law, pre Kendra's Law, is just as tough as Pennsylvania's. I easily could have ended up in jail, but I was so far out that they took me there. The problem was that they have a 72-hour evaluation period in New York. The doctors turned to my parents as soon as they got there which was a day later, and they said, once 72 hours is up we're going to have to let him out.

Why? Was I a danger to myself? I was

running from my secret agents for 72 hours. Was I a danger to others? No. I was running from my secret agents.

And while I would hope that there would be a little bit more of a practical application in the law among judges in Pennsylvania, that is a legally defensible interpretation of Pennsylvania's present law.

REPRESENTATIVE HENNESSEY: What I'm trying to get at is from your position as a patient or consumer, would it have made a difference to you if I was the judge and I said, I'm going to order you to get involuntary partial commitment or some sort of treatment, you haven't spoken out about it ahead of time, but I am telling you by virtue of the authority vested in me as a hearing examiner or as a judge, I'm going to make you do it.

Would you have reacted differently if I was able to say to you, I'm going to order you to undergo the treatment? You may not like it now, but six months ago you promised you would do this and, therefore, I'm going to order it and in a sense going to put the burden on your shoulders saying this is what you asked for, this is what you get.

As a patient, as a consumer, do you

think that you would have reacted better to it saying, hey, I cooked my own goose so I guess I have to go through with it? And would you then internalize any anger as opposed to being mad at me as the judge?

MR. STANLEY: I hate to not give a definite answer, but it would depend on my condition at the time.

REPRESENTATIVE HENNESSEY: Speak generally then. From what I hear from the advocates from the mental health side is let's empower the consumer to make those choices. I just think they run into the problem this woman says. By the time this person decompensates, he wants to tear up that contract and say, I don't care what I said then --

MR. STANLEY: Absolutely.

REPRESENTATIVE HENNESSEY: -- I don't want it now. What I hear them saying is, that it's better this way, that it's better that not me as a judge saying you're going to have it, but letting you stew in your own juice, so to speak.

MR. STANLEY: Look at it this way, if it's enforceable, if the person can't tear it up and walk away, it can't hurt if that's in play. You're never going to get 100 percent of the people to sign

these things.

REPRESENTATIVE HENNESSEY: Right.

MR. STANLEY: You're never going to learn when people have their first break, one they didn't even know was coming. I'm in favor of it, but you really have to -- the problem with it becomes that some people try to use it as a mechanism to avoid treatment rather than to get into treatment.

If you create a statute system to use it like you said to be used, then fine. You just have to be -- like I said, it's very complex in how you put the statute together that's going to govern the advanced directives.

REPRESENTATIVE HENNESSEY: Your earlier suggestion was to make sure that we apply this only in the most serious of cases, so that we look at the details of the language and say that it's not going to be a danger that --

MR. STANLEY: Well, I think --

REPRESENTATIVE HENNESSEY: It has to be something serious.

MR. STANLEY: See, the problem is you run into constitutional problems. There is a line for -- unlike what was said before -- when someone

can be forcefully medicated. And that pretty clearly from the Supreme Court and for almost all state cases is when a person is able to make an informed and knowing decision concerning the treatment. You can't let the advanced directives kick in before that point.

And then, in essence, it just becomes an alternative commitment because that's sort of the point -- well, that with a harm element is what we are talking about on this standard. So it would be an alternative standard that the person would create themself.

Now, where I think advanced directives rather than looking at when stuff can come in and when stuff can't, if a person when they are sane has certain treatments that have worked for them in the past and they know that they have worked for them to give them whether it's binding or not, that can be determined but at least the person basically says, Risperdal I have an intense allergic reaction to, I don't want Risperdal used on me.

Under some statutes, the doctors can never use Risperdal unless they went to a court and appealed to use the Risperdal, that type of thing.

REPRESENTATIVE HENNESSEY: No

alternative?

MR. STANLEY: Exactly. For me, rather than in how the treatment comes into play, it's more about what the treatment is for the individual person or at least that's the way it should be. That's just my personal opinion.

REPRESENTATIVE HENNESSEY: Thank you very much.

MR. STANLEY: Sure.

CHAIRMAN MAITLAND: Jane.

MS. MENDLOW: Thank you, Mr. Stanley. I want to compliment you for your contribution here today. You supplied us with a lot of important insights and facts.

MR. STANLEY: Thank you.

MS. MENDLOW: I was wondering if you could just clarify where your center is located?

MR. STANLEY: I'm sorry. It's in Arlington, Virginia. Skip a few stones over the Potomac and you'll hit the Washington Monument.

MS. MENDLOW: Great. I was also wondering if you'd be able to share with the committee and send some kind of an e-mail to Mike Schwoyer that would tell us more about how to get a copy of the report, the study?

MR. STANLEY: They should be right over on that table.

MS. MENDLOW: Oh, okay.

MR. STANLEY: There's a summary page and then there's the three actual studies.

MS. MENDLOW: Thank you.

MR. STANLEY: You're welcome.

CHAIRMAN MAITLAND: Mike.

MR. SCHWOYER: I was going to ask you if you could -- I believe you had Exhibits A through M. Could you provide us with just a sentence or two about each one, what it is?

MR. STANLEY: If I can get the cover sheet, I can explain or if I can just go back to the stuff on my chair.

CHAIRMAN MAITLAND: Go ahead.

REPRESENTATIVE HENNESSEY: I have to excuse myself, I have to be at a meeting that was set up beforehand. My apologies to any testifiers or anybody else in the audience, no offense intended by my leaving.

MR. STANLEY: All right. One, in setting this up, I tried to start with outlining the most severe problems that we have. And this parallels my testimony in many ways.

The first three deal with the homicides, suicides, and homelessness. All of them are fact sheets from my organization which compile what we think is a fair survey of the available literature.

The fourth one, Document D, is a DOJ report on how many people with mental illness are in our jails and prisons.

And then the next one, which is document E, is actually a compilation of various documents dealing with assisted outpatient treatment.

And, again, I'm sorry, but at this point because nobody basically doubts that there should be an inpatient hospitalization and some states have not yet adopted an assisted outpatient treatment. It's been that way for about 20 years. At least the current studies are much more about assisted outpatient treatment.

And as I see it, agreeing with some of the previous witnesses, the effectiveness will be to bring assisted outpatient treatment or outpatient commitment to Pennsylvania on a broader scope. And whether someone will be hospitalized briefly and then put in an outpatient -- basically, what you're

going to have is you're going to have much more use of the less intrusive outpatient orders.

I have some summaries in there. The Kendra's Law results that I read are in there, the briefing paper or fact sheet from our center, the three publications that -- at this point, there may be one more -- summarize what we know from the Duke studies, which, by far, are the best studies on assisted outpatient treatment.

And then we have a resource document from the American Psychiatric Association which has their findings on assisted outpatient treatment. And then there's an article by Dr. Fuller Torrey who is our President and Mary Zdanowicz who is our Executive Director on outpatient commitment.

And I'm glad nobody asked me a direct question about costs. There's just a dearth of studies and data on cost. Apparently in this field you've got doctors looking at the treatment, you've got lawyers looking at the laws, apparently accountants and economists just aren't interested because there's almost nothing.

You can make suppositions. And I can sit here and say, I think you're actually going to save money, but I can't prove it to you in any

credible way. My feeling is when Kendra's Law, the pilot for Kendra's Law, in an 11-month period the group without orders had 101 days in the hospital, the group with orders had 43 days in the hospital.

What we do have is a good study of just the law enforcement and criminal justice costs from California which showed that severe mental illness -- and it's a little unspecified as to what type of an illness, how severe, and where it comes, but they put the price tag for California in one year at $1.2 to $1.8 billion.

Document H, basically -- this is not the first state reform I've been involved in, so I can sort of anticipate arguments. It seems that people who are opposed to it, rather than saying I don't think this is right, they act like it came from the moon.

You have a sheet in there that compares Pennsylvania's present law, and that proposed by the bill with 15 other states. I think you'll find that it's not that unique a step for Pennsylvania to take. They're not paving the way, they're just following people that adopted these kind of things and found that they made sense. That's what the movement has been since these laws

were adopted -- not to where they were before because that was way far, but a measured step back to the point of what I would call common sense.

And we have the legal cases that I was talking about. We have in re: LaBelle from Washington -- this is I through K, not in that order I don't think. And then we have State versus Dennis H. from Wisconsin which just came out. I will say this has some very powerful language in it. I had to stretch myself to figure out which passage I was going to read to you today.

Then we have the amicus brief from my center which we submitted in the case of Dennis H. and which is not on the legal side because there were other ones that put that out sufficiently. And so we just wanted to get the policy decision before the court. Of course, the court said, we weren't thinking about policy, but we still do it.

Actually, I believe that's the end of the documents. Unfortunately, I have one that I sent to Utah instead of your office, so I'm not sure.

MR. SCHWOYER: Representative Hennessey asked some questions about these advanced directives. And based upon your familiarity with

advanced directives anywhere where they are used, my understanding of an advanced directive is that it would kick in, basically, when this law would kick in if the changes were made and that it would kick in when somebody has decompensated to the point where they can no longer rationally make decisions about their medical care.

MR. STANLEY: It could. And that's why, unlike some states, if you're approaching the constitutional line, which again I don't think there are any scholars that debate that the widest line is the ability to make treatment decisions combined with potential danger. That's the widest you can put it.

If the commitment and the advanced directive are the same line, then what you basically have is an alternative commitment. And you could combine it within the existing commitment just as guidelines to the court when it is initiated, because if somebody is putting the advanced directive into play and the person has lost the ability to make that treatment decision, I don't think the person is going to say, oh, okay, I'll go along.

MR. SCHWOYER: And you said when you

introduced yourself that you worked at a treatment advocacy center and that your mission is to advocate treatment. In your view, would this House bill negatively affect a person's ability to get treatment?

MR. STANLEY: Could you clarify that a little more?

MR. SCHWOYER: There were opponents to the legislation who -- at least my take on their testimony was don't do this bill. We need more money for treatment. Don't do this bill, we need better treatment. Don't do this bill --

MR. STANLEY: Okay. Again, the economics of it, I can't say specifically whether you are -- the people that are involved in the law -- whether it's going to end up costing Pennsylvania more or less because you put them in treatment because there are going to be savings all over the place.

For instance, one good economic study that is not directly on this that came out, the University of Pennsylvania studied New York's program to place people who are homeless with severe mental illness into housing. Admittedly, one person in this program cost something like $42,000 a year.

But then they started adding up the savings, arrests, jailings, being imprisoned, those hospital days we talked about that were decreased, etc., etc.

All of a sudden it turned out that what they were paying to have somebody in intensive services for one year -- and I will say that even *though it wasn't according to this type, it was a* type of coercion because at least for a good portion, the most severely ill if they went off their treatment, they were out of the program.

But it cost about $1500 a year per person. And I think you'll see something like that in terms of the effect and the cost in this area. Even if it did cost, we're talking about the people who are the most ill of the ill.

MR. SCHWOYER: Thank you.

MR. STANLEY: You're welcome.

CHAIRMAN MAITLAND: Thank you very much, Mr. Stanley. We appreciate your testimony here this afternoon. And if we have any questions, we can get in touch with you later, right?

MR. STANLEY: Yes, please.

CHAIRMAN MAITLAND: Thank you.

MR. STANLEY: Thank you.

CHAIRMAN MAITLAND: Next we have Mr.

Tony Salvatore from the Montgomery County Emergency Services.

MR. SALVATORE: First of all, I want to thank the committee for paying attention to this very important piece of legislation that potentially affects everyone in Pennsylvania. This legislation is something we deal with every day.

I work with the Montgomery County Emergency Service, and this legislation is something we deal with every day. In Montgomery County, we are emergency specialists. We get the call, we're there with the first responders, we're in the door, mental health delegates are our staff. I brought one with me today. He's going to speak to you in a few minutes. We've heard from the families, like you have, every day. We handle more than 100 petitions a month.

What I would like to do, in deference to the hour and the patience that everybody has shown, is ask a couple members of our staff who can speak to the issue more clearly than me to join me. I'll start with William Leopold who is our Administrator, Paul DeMarco who is the Chief County Delegate for Montgomery County, and Don Kline who is the head of our Criminal Justice Department.

All of the functions that you have heard alluded to today, these are the gentlemen that deal with them.

MR. LEOPOLD: Thank you. Hi, I'm Bill Leopold, the Administrator of the Montgomery County Emergency Service which is just down the road from here.

We are a 73-bed nonprofit emergency psychiatric hospital in Norristown, Pennsylvania. We provide an array of crisis intervention and stabilization services as a 24-hour-a-day facility. We have psychiatrists twenty-four/seven, a mental health delegate. We are the enhanced 911, so if you make a telephone call that someone in your family is suicidal, that call comes enhanced into our building 24 hours a day. We have a licensed psychiatric ambulance program, licensed EMTs who go out often with the police when the warrant gets served with psychiatrically trained individuals to do that EMT function. So we have all these 24-hour-a-day services centrally for the county in the one location.

We have had 11,000 emergency admissions in the last five years. The gentlemen that are about to speak have a lot of front-line

experience in these situations.

We also are very clear in our mission of accepting anyone without the insurance question being asked up front. About one-third of our patients have no insurance upon admission, about another third have some version of Medicaid, so we really provide full access. When people talk about problems in the system, no matter what you have of an involuntary situation, you must have a place to take somebody and somebody that can handle that.

We've had national recognition from Dr. Torrey, from Congress and from the American Psychiatric Association for our diversion services as exemplified by the statistic that here in Montgomery County where we directly provide the psychiatric forensic services in the correctional facility and have a social worker in the prison, a social worker helping people transition from the prison and a number of intensive case managers on the forensic side.

Less than 3 percent of people in our local correctional facility have a serious and persistent mental illness as opposed to something like 10 to 15 percent as the nationwide baseline. So that's been a major focus. We started, in fact,

based on some suicides in the county prison close to 30 years ago. And while maintaining all of those 24-hour-a-day intensive psychiatric services, we are also very much focused on our mission of forensic diversion so people have appropriate treatment within the mental health system.

With that in mind, let me now introduce Paul DeMarco who is the Assistant Director of our Crisis Department, and he is the Chief Delegate from Montgomery County.

Thank you.

MR. DeMARCO: I was going to talk a little bit today about comments on the amendment. The proposed amendments address many concerns voiced by families of seriously mentally ill individuals over the years. As a matter of fact, I was wondering if some of our constituency, the residents of Montgomery County, provided any information to this committee, because we have been mentioning to them for years that when they find that the commitment procedures did not work for them in their particular situation that they needed to address that with the Legislature.

We deal with many, many families. We process, as Bill mentioned, about 100 petitions for

involuntary hospitalization each month. For each of these petitions that we actually follow through with the process, there are at least one or two other family members or interested parties who come to us seeking assistance on behalf of a friend, a relative, a neighbor who is suffering from mental illness.

In many cases, help can be provided without the need for commitment. Where commitment appears appropriate, families and others can be aided in navigating the legal process to assure a necessary treatment balance by the protection of individual rights and due process. These assurances must be kept in mind when making any changes to the criteria. We must make sure that the pendulum does not swing too far in protecting community safety at the expense of individual rights.

The following changes in the legislation that we do support are adding the ability for the mental health delegate to consider an individual's past treatment history, diagnosis, and behavior when deciding whether current behavior does constitute a clear and present danger, including cruelty to animals and intentional significant damage to substantial property in

determining dangerousness to others.

We have had at least one commitment that I can remember in my tenure here at MCES where an individual, a child, I believe, was severely mentally ill and was ultimately released by the court because they considered the cruelty in this particular circumstance -- it was an actual killing of the beloved family pet. Ultimately, the individual was let go by the court because they considered it property damage. And there are many other examples along those lines.

We do have some concerns regarding the following changes. Currently, the law has as an ultimate criterion a threat and an act of furtherance in some observable tangible act that clearly indicates movement toward a dangerous act for issuance of a warrant. The amendments set the criterion as behavior supporting a conclusion that there is a risk of dangerous behavior when looking at the totality of the circumstances. However, there does not appear to be a level of severity in this statement of risk.

The setting of the criterion for commitment too low may actually lessen the incentive to work with a treatment resistant individual.

The restrictions that come with being involuntarily hospitalized should not become a factor until the individual is actually found committable at a court hearing, at the 303 hearing and the filing of the documentation at the court.

And, also, as many other people have mentioned, it must be kept in mind that loosening the criteria for commitment will increase the number of individuals vulnerable to commitment, a process that is inherently stigmatizing. It may also involve a forfeiture of the Second Amendment rights under Act 77.

As kind of a brief -- I'll try to make this brief -- example, take two individuals, both are graduating from high school and going to college. They both come home for, let's say, Thanksgiving break -- and these are actually based on actual events, actual cases.

The one individual while at college suffers a significant and profound first psychotic break, comes back to the home and -- without all the details, I'll try to make this short -- does not act in a manner that with the current legislation is committable. He makes no threats, makes no acts of furtherance, but because that he believes that there

are cameras pointed at him he's very delusional, very paranoid, and literally destroys the inside of the residence. Under the current legislation, that would not be committable.

Let's take another individual who also comes back home from college who is now being introduced to in his mind new and exciting ideas and now comes home full of the ability to argue with his parents regarding his new found belief systems that have been changed by exposure to other individuals, who is not mentally ill but has a bit of an anger management problem and ultimately -- again, similar behavior, no threats, no acts of furtherance, no overt acts of dangerousness, but destroys the house. Under current legislation, that individual cannot be committed.

With the current amendments, with the acts of destruction of property, both of those individuals can be committed. The individual who comes back who is not suffering from a severe mental illness is committed.

Let's just say for the sake of argument that he persists in making some statements that leads the doctor to believe that he may be suffering from a mental illness. During the course

of treatment, prior to the hearing, the individual realizes the significance of his behaviors, talks to the doctor, there are family meetings, and ultimately it's decided that the person is, in fact, not severely mentally disabled and is not in need of further commitment, is released from the facility thinking that he, quote unquote, dodged the bullet.

He goes back to college, decides to pursue an activity such as hunting, goes to purchase a firearm, cannot because of Act 77, goes to try to find employment because he wants to get a lawyer to get his records expunged, goes to fill out an application, at the bottom right-hand corner of that application it says, have you ever been committed? Now, this individual, based solely on his temporary lack of judgment now has to consider whether he is going to truthfully answer that question and try to argue his case with a potential employer or whether to lie on that application and be subject to possible future impingement on his employment.

One of the suggestions that we are making here is that, if appropriate, if the committee feels it's appropriate, to move some more of the onerous aspects of the commitment process to actually begin to take place at the 303 hearing

rather than at the delegate and the doctor level, the commitment hearing providing some additional legal weight to the definition of being committed against one's will.

There are a lot of circumstances where people do not end up going to a commitment hearing because we are able to work with people on an intensive basis. And if it's not found that they are in need of continuing treatment and are, quote unquote, not committable, they still suffer these rather large ramifications of being committed.

Thank you.

CHAIRMAN MAITLAND: Thank you.

MR. KLINE: Good afternoon. My name is Don Kline. I'm the Criminal Justice Director for Montgomery County Emergency Service. I'm going to back up what my colleagues have just said and add a few things.

Montgomery County is very rich in services for mental health, drug and alcohol, behavioral disabilities. Currently, in our county correctional facility we have 1.75 percent suffering from severe and persistent mental illness which is far below the national average across the country. As Mr. Leopold was saying earlier, we are quite

unique in the country and we provide services that are quite different from the rest of the country.

My fear is that services being provided across the country are not as good as some of the services that are provided in this county and people will fall between the cracks because the services out there, the service providers out there, are not providing the services that they are slated to provide. Therefore, there is an increase in police contact with persons suffering from mental illness. Some of the changes in the law will increase the contact with local law enforcement and may negatively impact the criminalization.

Our job is to reduce that criminalization and keep individuals out of correctional facilities where they don't belong. Across the country, if you look at the reports, and I have cited a few in the report that I gave you, that police officers, law enforcement officers -- in the community, it's a lot easier for them to criminalize a consumer suffering from mental health for a variety of reasons. One is to get them treatment because treatment is not readily available in the community which is a tragedy, a travesty of the current system which needs to be changed.

I am a firm believer in training local law enforcement -- in fact, that's what I do in the community, the front line individual. I'm also a county mental health delegate, so when the decision to issue a warrant is very heavy with the impacts with that individual, the family, the community, protecting the individual as well as the society as a whole is a very heavy decision to make at the initial contact with the petitioner.

I do agree with the wording of totality of the circumstances because you do have to take everything in account. I do believe that in Montgomery County that's what we do. We do look at the totality of the circumstances. And we look at that as a whole when we are issuing a warrant to have somebody brought in for an evaluation.

As Mr. DeMarco said, I would caution on a few of the recommended changes that may be a little bit too broad but to maybe leave the discretion, as Mr. DeMarco was saying, with the delegate or to have the severe impact of Act 77 then put onto the mental health review officer would probably be a better change or addition to the current House bill.

Just a couple other quick questions

because I know it's been a long day for everybody. In 1975, there was a U.S. Supreme Court decision which allows individuals in the community who have psychiatric illness not -- they don't have to be forced medication. That was a Supreme Court decision. I wanted to throw that out.

There is a way to force medical treatment on individuals through -- in our county, we use the Orphans Court to have a judge review the circumstances set forth by a medical practitioner physician to make a decision to force medical treatment. Medical treatment and mental health, they are not -- you cannot use the Mental Health Procedures Act to force treatment, medical treatment, on anyone. People do have a right to make a decision of what they would like to have in the community.

I am for the use of -- I can't think. It's been a long day. I am for the use of the advanced directives. However, it is true that I could write this down, I want to take this medication, this treatment, but once I'm decompensated and the thought process is not going well, I can refuse that and that's a catch that needs to be addressed.

I do believe in training, cross training local law enforcement and the mental health community to provide services in the community, front line services, for stabilization and support to reduce the conflict and to try to provide community-based services and support versus hospitalization and even forced treatment.

So I'll keep my statements brief. Thanks.

CHAIRMAN MAITLAND: Thank you. Any questions?

Mike.

MR. SCHWOYER: I just wanted to address generally to the persons who provided testimony and were here throughout the day that we are always willing to look at amendatory language so that if anybody could offer up page and line number suggestions for improvements to the legislation and that's why we're here today.

CHAIRMAN MAITLAND: Thank you very much.

MR. KLINE: Thank you.

CHAIRMAN MAITLAND: Our last testifier is Carol Aitken.

MS. AITKEN: Nothing like being the

tail end of the donkey here, but hopefully I'll be worth staying for.

First of all, I would like to commend Representative Maitland for sponsoring this bill. It's a much needed revision of some old laws. Before I get into my testimony, I'd also like to offer a few brief comments about prior testimony.

Let me position myself. I'm a business executive. I've been in the executive search industry for the past 30 years. I've placed executives all over the world. But most and foremost, I'm a mom. I have a daughter who is bipolar. She has a brain disease. I don't really think of it as a mental illness. I think of it as a brain disease, like heart disease, diabetes, any other disease.

Before I get into my testimony, as I mentioned, I would like to recommend a book to all of you to read if you haven't read it yet. It's a quick read, 100 pages, quick and dirty by this Mr. Amador that was mentioned in previous testimony. It's called I'm not sick, I don't need help. You can get it on Amazon, that's probably the quickest way. I don't know if they have it in the bookstores or not. Amador, I am not sick. I don't need help.

You will be educated like you have never been educated before about what goes on in the mind, why they think it's a frontal lobe dysfunction and why people think that they don't need meds. It explains it in detail. It's one of the best things that I've ever read, and I've read hundreds of books on this illness, believe me. It's quick, dirty and it'll get you educated very, very quickly before you vote on this legislation.

Another thing I would like to address is the advanced directives. I've seen them. My daughter has signed one. We had our family attorney look at it. He says there are so many holes in it, you can drive a truck through it. Yeah, you know, you can put down I don't want to be given this medication. I want to go to that hospital. But in reality, if the hospital doesn't have a bed, you're not going to that hospital.

Medications are decided by doctors. You can say, hey, Thorazine makes me crazy, use something newer. That may or may not work, but I'm here to tell you if you've got a smart person like my daughter, she is going to work her way right around these laws and take the advanced directive and rip it up and throw it at the judge. She's

sick.

When she's well, she's an outstanding member of the community, has always been fully employed, goes to school. In between her 14 hospitalizations, she's managed to make it to junior status with a 3.75 GPA. When she's sick, it's sort of like when she's -- what is that little nursery rhyme, when she's well, she's well -- believe me, I've been there.

All right. To get into my testimony, I would like to share with you some of my experiences in dealing with the present involuntary commitment laws in the state of Pennsylvania -- by the way, we live in Chester County -- and have provided you with a summary of the patterns of my daughter's hospitalizations over the years as an example of how a person's history and diagnosis should be considered when a parent or loved one recognizes that the person is starting to get sick again.

It may be very subtle. It may be the fact that I get an e-mail from her one day and it's great and it's lucid and then it's a little off and you think, hey, something is going on here. It may be that she takes the dog out for a walk and leaves

the dog somewhere. Oh, I just thought she'd walk home by herself, very subtle when people are starting to go into these illnesses.

The last sheet that I have attached is sort of a legal history of patterns of my daughter's hospitalization starting in 1986 when she was first diagnosed with bipolar disorder. It broke my heart because that week I was attending a meeting at the University of Pennsylvania with her older sister. She was being, I guess, installed as Vice President of the College of Engineering at University of Pennsylvania.

Later in that week, I attended my 16th -- my daughter's 16th birthday party in the psych ward of a hospital in Texas. This is a child that I had hopes and dreams for, as well as she did. And yet this started a journey for us that was tougher than anything I've ever experienced in the corporate world. The corporate world is child's play in comparison to dealing with what you have to deal with when you have a loved one with a severe brain disorder.

She was well for about three years, went away to college and because of her brain disorder had to see the nurse twice a day for meds.

So she was well for three years. Actually, this was a private boarding school at that time in North Carolina. The doctor suggested it might be best for her to have boarding school before she went on to college to learn how to adjust.

After successfully going through boarding school and entering school in 1989, she couldn't cope with it, went off her meds, was hospitalized in Rhode Island. I didn't list a lot of these on here. There have been 14 hospitalizations. I've just gone through a few of them. You can read it for yourself, '89/'90.

In '90, the police found my daughter wandering around, walking around in a park naked. Apparently, this is a big thing with bipolar. They take off their clothes and roam around. They found meds in her handbag and took her to a hospital.

In '91, she ingested many pills from the medicine cabinet and was in the ICU having her stomach pumped and being treated. Those were sort of semi-suicide attempts, I guess.

She was well for about five years, married, continued on with school, worked full-time, real popular in the community, well-known. And during that period of time, we appeared on a talk

show and talked about her illness. It was very interesting, how well she performs when she's well and how weird she is with the illness. Conversely, when she is off her meds, she is totally unaware of how sick she is and doesn't want to be medicated. She thinks she is being poisoned.

In 1996, the police chased her for ten miles going 120 miles an hour in a sports car that she had just bought. That's another thing they do, they buy cars. That was mentioned before and I thought, oh, I've been there.

She was hospitalized in Delaware, and she knows the system so well that she knows that the HMOs give one month. If you resist taking meds for two weeks, and you know it takes about a month for the meds to kick in, then you have a few more weeks in the hospital taking meds but then you get out and you stop taking them right away. And that's exactly what happens.

In 1996 after she was released from the first hospital, we tried for three months to get her hospitalized. She lost so much weight that she was close to death and they again hospitalized her. And, of course, she refused to take her meds. The judge ordered her to take her meds, so forth and so

on.

This trying to get a person hospitalized in Pennsylvania is a nightmare in green with the present laws. You can call crisis. They say, well, have you seen her? What's she been doing? She's not sick enough. She's not sick enough. You call two weeks later, telling them what she's been doing, supply voice mails, whatever. She's not sick enough. She's not sick enough. And it goes on and on and on until the person has decompensated to the point that they are really, really sick and can either be picked up by the police or whatever to get them hospitalized.

Okay. So this goes on year after year. She gets better, she goes to work, she's fine, she gets sick again. Sometimes she doesn't just stop taking her meds.

In one instance -- and this was in the 2000 hospitalization, I guess -- she -- one of her doctors said that her teeth were bad because she was not taking enough calcium. So she started to take extra calcium, and guess what? Calcium bleaches Lithium, because they are both salts, right out of the system. And then guess what? She didn't need her meds anymore and she got sick. That's a whole

other -- we won't go into each and every one of these.

In the most recent case which I would like to address because I think it's -- it illustrates kind of what we've been -- I could talk for days and days and days about all these hospitalizations, but let's talk about the most recent one.

Her episode began in April of 2001. She was under some pressure at work in a new supervisory position. By the way, her company was aware of her brain disorder and had supported her fully in her previous hospitalization. When she came back to work everybody was, like, gosh, I'm glad you're back and blah, blah, blah.

Indeed, six months after she returned from the hospital, she was promoted into a supervisory position supervising six people. She somewhere along the line, I guess, with the stress of supervising people and so forth -- and it's not clear exactly what happened -- she maybe forget to take her medicine in the morning and then at night. Something happened and obviously she stopped taking her meds because she started to very slightly exhibit symptoms that a mother can recognize. I

don't know why the medical system and the crisis people can't. I mean, I can. Within two days of her stop taking her pills, I can tell.

Anyway, along about this time I had to go to Florida. I wasn't sure if she was ill. She swore she was taking her meds. I had to go to Florida to take care of ill parents. Along about the same time, her father had moved to the state of Texas, became ill and was hospitalized. She sort of supervised over the phone, coordinated with doctors for the rest of the family, and, you know, sort of supervised that, which put her under more stress.

She started to act out. A neighbor called me. I thought, what can I do long distance? You know, I can't come back and get her hospitalized because she's going to run. That's what she does. She doesn't want to be anywhere near me when she starts to decompensate, because she knows that I'm quick enough and fast enough -- and, boy, you have to run fast to be faster than my daughter to try to get her hospitalized. I know the laws pretty well, but I think she knows them better than I do.

Anyway, he did die from his illness. She flew to Texas and arrived in Texas without her luggage. She left it in the cab, and then my

brother-in-law and all the members went around to try to find it and everything else. Well, she bursts into the scene trying to take control of the situation. Of course, she was in high mania by then. They calmed her down and everybody went to bed.

Well, during the night -- you see, bipolars don't sleep. When you're bipolar, you don't sleep at all. And she very quietly packed the contents of the house into a car and took all of the funeral arrangements and everything, the papers, and put them all over the floor in a trail in some symbolic thing to her, took knives out of the drawers, found a gun and bullets that he apparently had in this drawer that no one knew about -- I mean, after all he did live in Texas -- and scattered them all over the floor. It was a nightmare.

Everybody woke up in the morning to see this truck packed with all sorts of household goods, and jewelry, and artifacts, and you name it. And my daughter is sitting there. Well, they called the crisis center, what do we do? Everybody was, like, what do we do? What do we do?

You have to understand, I have been dealing with this on my own for years. The family

is sort of long distance. They sort of know she has a problem, but they never lived it. They've never lived it. Now they were living it. There were eight of them. There is only one of me. And they had to deal with the crisis.

So they called the crisis, the CIT team in Houston, Texas. They responded with all sorts of police cars and their team. At one point they even sent a helicopter, if you can believe that, because she was running around and they were trying to chase her running around in her bare feet.

Finally, they caught up with her. And the crisis team talked and talked and talked to her and they said, boy, we've never seen anyone like this one before. She knows the laws cold. You know, we can't get her hospitalized. I mean, she knows what to say. She knows how to keep calm. We just can't hospitalize her. We don't know what to do.

So she managed to go to the viewing, and so forth, and get through that and then proceeded to leave. She hired a limo, by the way, to come and get her and then decided to stay at the Four Seasons or someplace in Houston, Texas, a nice five-star hotel. You see, they do spend a bit of

money while they're sick. That's another thing that people with this illness do.

And, anyway, after a period of time they couldn't catch her and nobody could do anything. She was calling me and leaving voice mails, which, of course, I left on the voice mail system so I had this trail of evidence, if you will, that hopefully would help to get her hospitalized.

She opted to hop on a plane and go to North Carolina to her old boarding school to visit friends. However, when she arrived in North Carolina, she thinks that she lost her bags. That's when she called me and said all her luggage is gone and she didn't know what happened to her luggage. She was found wandering around in a Wal-Mart trying to buy clothes to replace her designer duds. She landed in Wal-Mart and was trying to buy clothes. And, apparently, they thought her behavior was bizarre. I don't know exactly what she was doing, but they called the police and she was hospitalized in North Carolina.

They kept her for about 13 days. They told me how terribly, terribly ill that she was. I sent letters, all sorts of records and so forth, but you know, the HMO says up and out, so out she went

again. She continues on her journey and ends up in Baltimore, where I later discovered she tried to buy a gun but couldn't because by then she was psychotic that people were chasing her. Keep in mind she was released from a hospital in Texas, which I forget to state, and she was hospitalized, and then in North Carolina.

We're now about to May 17th. This saga began around the first of April, May 17th. Just think in your gut what that does to you as a parent to try to fight these systems in various states with your child running around like this. Okay. She was -- instead of coming home, because I'm the enemy at this point, she stayed in a motel, I guess, because she was running out of money.

She called the police here in Pennsylvania -- this was Delaware County -- and said that she had a knife and people were trying to climb through the walls to get her. So the policemen responded, said she just had a little pen knife. They got a hold of my name and phone number and called me and said, obviously, she is not right. I explained, hey, she's bipolar. I can give you all the information. Where are you going to take her?

They took her to the hospital. I went

to the crisis center, sat and talked to them with all of her records and hospitalizations, etc., etc., wanted to do a 302. Well, Mrs. Aitken, have you seen her with your own eyes in the past 30 days? No, but I have all of these voice mails. I have all of this correspondence that she sent, etc., etc. Well, if you have not seen her yourself and have not observed the behavior, according to our laws in the state of Pennsylvania, then you can't sign the 302.

Fortunately, one of the young patrolmen said, look, she is really sick. I'll sign it. I know we're not supposed to, but, look, she's really sick and I will sign it. By the way, she did mention in the squad car when they brought her over here that she loved her mother, but she would kill her mother if her mother tried to make her take her meds.

Of course, now she's just horrified that she said that or would even think it. But when a person is off of their meds, this is how the mind works. And reading the book, I'm not sick, I don't need help, will give you a little bit more insight of what goes on.

She was in the hospital, and I wrote a letter to the Director of Psychiatry at Brandywine

Hospital begging him to keep her in the hospital, asking him to sign on a 304 commitment that would keep her in the hospital longer. They looked at the HMO papers and were talking to the doctors at the HMO and, of course, she had X amount of insurance; therefore, out.

I said to them that, gosh, basically, we'll sue you if you don't keep her in the hospital because she's sick, you know it, you have all this evidence, etc., etc. They let her out. They just kind of blew me off and let her out.

Again, she ends up in another motel room. She starts leaving more crazy messages for me on the voice mail machine. I didn't pick up the phone. I just wanted her to leave voice mails. Then she made her mistake. She drove up and gunned her motor outside of the front of the house like she was going to drive into the house and starting yelling out of the window. Therefore, I had seen her with my own eyes and I could then 302 her myself because I had actually saw her.

So I went down, filled out the papers. By then I was working with advocates and everything else trying to figure out how I'm going to get this done. They suggested that we get her hospitalized

in a clinic, because they were less likely to let her out of there until she was well. So they took her to the clinic and from there -- of course, she refused her meds. The judge said, you have to take them. The doctor said, we'll fix her because, you know, they smoke while they're sick -- I don't know whether you know that or not, but that's another sign that you can tell. A person that hates smoke, that detests it, will start smoking because of the ceratonia uptake. So, anyway, the doctor in the hospital said, no smokes if you don't take the meds, and they're frantic to get smokes somehow. So, anyway, she did start taking her meds.

They were clever enough to figure out a way to get her into Norristown State Hospital. She was frightened to death of going to a state hospital. I was mortified. Oh, my God, a state hospital. She's always been in private hospitals. Let me tell you, Norristown State Hospital is one of the neatest places. They have the best staff. It looks like a college campus over there. Wonderful, wonderful environment. I can't speak highly enough about that institution. These people are sharp. They know what they're doing. And they weren't going to let her pull her -- you know, whatever she

did. She knows the laws. They know them better than she does. So she just wasn't going to get away with anything at Norristown State. I thought, finally she's met her match. It worked out very well.

Now, keep in mind the saga began in April of '01. She was released from Norristown State Hospital in November of '01. She was released to a -- I guess it's a semi-hospitalized type situation. It's an apartment. And they have a number of different apartments there. She's monitored. She has to come down to the second floor to get her meds twice a day.

She's now back in school full-time. I just read yesterday a -- something that when she came over to visit me, she had a little letter from the president of her college saying that she is on the President's List instead of the Dean's List because she's doing so well.

If my daughter had a heart disease rather than a brain disease, she would be treated with dignity and respect rather than having to be captured by the police like a common criminal in order to get the medical care that she needs.

I am very much in favor of

strengthening these laws to help people that can't make decisions on their own when they're ill. That's part and parcel of the illness. When they get sick, they don't know they're sick and they're going to refuse medication. It's very, very important that these laws be strengthened.

I welcome any questions.

CHAIRMAN MAITLAND: Any questions?

MR. SCHWOYER: None.

MS. MENDLOW: Yes.

CHAIRMAN MAITLAND: Jane.

MS. MENDLOW: Ms. Aitken, regarding the issue of the hospitals and discharging your daughter because of her lacking certain medical insurance, can you just give us a very brief point on that, do you want to elaborate, i.e., did they basically say, you only get coverage -- at one point when she had an HMO, it was a 30-day coverage, but then she was discharged automatically, you're saying, because the HMO didn't continue coverage beyond that point?

MS. AITKEN: That's a real interesting little loophole. What you'll find is you'll be talking to the nurses on the ward if she gives permission for you to talk to the nurses on the

ward, which she does sometimes, other times she doesn't.

MS. MENDLOW: Okay.

MS. AITKEN: And they'll be saying how sick she is and, oh, my God, she's one of the worst I've ever seen. Well, 24 hours later she'll be released. And the doctors magically say that she's gotten better.

MS. MENDLOW: Okay.

MS. AITKEN: Well, you and I know that if the cash stops, then she's going to be bounced out on the street, unless a judge says, hey, she's staying in here or she's going to another facility.

MS. MENDLOW: Okay.

MS. AITKEN: But it's a loophole and the doctors use them all the time.

MS. MENDLOW: Okay.

MS. AITKEN: Because the HMOs cut off the money and they're not going to keep her there. I've even had social workers say, wow, she only has X number of days. I can't tell you how many times I have heard that in her hospitalization. And she knows that if she resists medication for long enough that, you know, the time is up. She is going to be on meds for a couple of weeks and then she can just

go off them as soon as she is released.

MS. MENDLOW: Thank you.

MS. AITKEN: It's one of the dirty little secrets.

MS. MENDLOW: Thank you, Mrs. Aitken.

MS. AITKEN: My pleasure.

CHAIRMAN MAITLAND: Do you believe that if this bill had been enacted that you would have been able to get her help sooner?

MS. AITKEN: I sure do.

CHAIRMAN MAITLAND: And it would have been less cost to everybody involved?

MS. AITKEN: Absolutely, positively, without a doubt.

CHAIRMAN MAITLAND: I see.

MS. AITKEN: And I am just really shocked that there aren't more parents and, you know, loved ones testifying at these hearings.

CHAIRMAN MAITLAND: Right.

MS. AITKEN: It sounds like all of the local mental people are around, but what about the ones that are living it? I've lived this for the past 16 years.

CHAIRMAN MAITLAND: There's a number of them in the audience here.

MS. AITKEN: I'm glad.

CHAIRMAN MAITLAND: Plus, we had several people submit letters for the record that aren't formally presenting testimony verbally today, but we have five or six letters so far.

MS. AITKEN: Good.

CHAIRMAN MAITLAND: And also a week from today, we're holding a similar hearing on the same topic out in Pittsburgh.

MS. AITKEN: Yeah, I wish I could be in Pittsburgh to testify again. I really do commend you for bringing this up. It's long, long overdue.

CHAIRMAN MAITLAND: Thank you very much.

MS. AITKEN: You're quite welcome.

CHAIRMAN MAITLAND: Anything else?

Well, I'm sorry we went an hour and 45 minutes over schedule, but it certainly was interesting and educational for me.

MS. AITKEN: Yes, it was.

CHAIRMAN MAITLAND: We would like to thank the Borough of Bridgeport for the use of their facility. I thank the staff for their hard work in setting this up. And I thank you folks in particular for attending and testifying and helping

us to move this issue forward.

On behalf of the House Judiciary Committee, thank you very much. This hearing is adjourned.

(The hearing concluded at 1:55 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Jean M. Davis, Reporter
Notary Public

Notarial Seal
Jean M. Davis, Notary Public
Derry Twp., Dauphin County
My Commission Expires Mar. 29, 2004
Member, Pennsylvania Association of Notaries