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

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

GREEN TREE FIRE HALL
825 POPLAR STREET
PITTSBURGH, PENNSYLVANIA

WEDNESDAY, JULY 31, 2002, 9:02 A.M.

BEFORE:
HON. STEPHEN MAITLAND, CHAIRMAN
HON. DONALD WALKO

ALSO PRESENT:
HON. THOMAS STEVENSON
JASON KLIPA
JANE MENDLOW
MICHAEL SCHWOYER

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I N D E X

CHAIRMAN MAITLAND: Good morning, ladies and gentlemen. We will call the meeting of the Judiciary Task Force Committee to order.

My name is Steve Maitland. I'm the Chairman of the Task Force. I'm the State Representative of the 91st District in Adams and Franklin Counties.

I'm joined here today by Representative Tom Stevenson of nearby Green Tree. And to my right is Michael Schwoyer. He's chief counsel to the House Judiciary Committee. And down at the end there is Jane Mendlow. She is the staff person for the Democratic Chairman, Kevin Blaum.

The purpose of the Task Force today is to examine and take testimony on House Bill 2374, which is an amendment to the Mental Health and Procedures Act on involuntary commitment standards.

I introduced this in response to a constituent who is going to testify later here today about the problems that she encountered with the inability to get someone who desperately needed treatment into treatment. The person doesn't voluntarily want to go.

This is the second of two hearings. We had a hearing last Wednesday in Bridgeport in

suburban Philadelphia. We had a lot of good testimony, a lot of arguments pro and con about this legislation, and a lot of suggestions on ways to improve the bill.

The purpose of the Task Force is take a rough piece of legislation and try and get it into a better form for consideration for the full Judiciary Committee. Therefore, it's the goal of this Task Force to end up with after the amendment process a more complete and more final version of the bill that the full House Judiciary Committee can consider.

With that, I will ask our first testifier to come forward. Barry Fisher, Dr. Barry Fisher from the Pennsylvania Psychiatric Society.

MR. FISHER: Good morning.

CHAIRMAN MAITLAND: Good morning.

MR. FISHER: Thank you for inviting me here to represent the views of the Pennsylvania Psychiatric Society. I should add that I'm also an employee of the Veterans Administration Hospital here in Pittsburgh.

You might be puzzled that a psychiatrist and a psychiatric society would oppose a bill that is a bill that makes it easier for us to

get patients necessary care before dangerous behavior occurs. We, like the families and other members of society who support this bill, would like to prevent dangerous events from occurring that are secondary to mental illness.

Why would we oppose it? Well, as you know, commitment laws are by their very nature coercive so that when we are looking at forcing somebody against their will into a treatment, we do have to balance the desire to get them necessary treatment with supporting their right to self-determination and individual decision-making.

We believe that the proposed changes in this bill sway too far away from an individual's ability to make personal decisions and it undermines self-determination.

As a clinician, I know that the most powerful tool that I have in getting patients to participate in their care and to agree to my treatment recommendations is the sense of trust that they have in me and the therapeutic relationship that we have together.

Again, by its very nature, a commitment is a coercive interaction and tends to place the patient in a position where they are not

feeling empowered, they are not an equal player in the relationship. And while they may be prevented from harm in the short run, the harm to the therapeutic relationship can be so severe that what we see rather than an improvement and understanding of their mental illness, we would see a revolving door in the hospital, out of the hospital, in the hospital, out of the hospital and so on.

One of the biggest concerns that the society has, and myself in particular is the vagueness of the predictive factors that can lead to an involuntary hospitalization. Dangerousness, of course, is quite clear. But as you will hear from other people testifying today, that may seem to be so restrictive that people don't get care. And I can appreciate the concerns involved in supporting a desire to get people to care before a bad event has occurred.

On the other hand, what sort of behaviors are predictive of decompensation? What if the patient with religious delusions who has a history of vandalizing churches and other buildings when he is psychotic and you learn that he is starting to attend his own church again more regularly? The family knows that this has often

been one of the behaviors that leads to deterioration and potential acting-out behavior that is secondary to the mental illness.

Do we at that juncture when the person is attending church bring them into the hospital because we know that that is a sign that they are getting worse? I believe that if we do that, we are leaning too far away from the person's rights to self-determination.

Another example might be a patient with a history of bipolar disorder who has had a history of spending money when manic and exhausting the family's funds. He chooses at one time to purchase a vehicle that his spouse doesn't agree that they should have. Is that a sign of deterioration or a difference in opinion between his spouse and himself on how to spend their money? The vagueness is, I think, what we have trouble with in this legislation.

Another thing mentioned is cruelty to animals. And while I'm a dog lover, I have two dogs myself and I abhor the idea of people being cruel to animals and certainly would want to prevent it if it's secondary to a mental illness; in point of fact, cruelty to animals is a rather rare event in

the chronically mentally ill and is more typical of anti-social tendencies and criminal tendencies.

And I think inclusion of that criterion in this bill has the potential to fill our hospitals with people who might otherwise be more appropriate for the legal system.

One of the other concerns that I have is something that is applied by this bill, and certainly I would agree with it, is that stopping medications is one of the great predictors of deterioration, particularly with psychotic disorders, manic depressive disorders.

On the other hand, patients truly have unpleasant side effects from some of the medications. To coerce a patient into a situation where they are not able to express their desire for something different by refusing treatment, in other words, by having the threat of hospitalization and coercion as the primary means of getting them to comply with treatment, we really undermine the therapeutic alliance and we also prevent a necessary dialogue between the patient and the physician about issues like side effects and compliance. I see that as a concern.

And while I would certainly like to be

able to get my patients to take their medications when I know that they are helpful, I also know that there are times that they refuse the medications and it's probably been the right thing and a wake-up call for me to make appropriate changes in the treatment.

If we at the Pennsylvania Psychiatric Society agree in principle with the goals of this bill, but disagree with the actual bill itself, what can we recommend that we think would help support our desire to get greater access to care for patients who may be decompensating? There are several impediments to care that we would like to see legislation change.

One are restricted formularies. Again, a reason that patients are often noncompliant with treatment is side effects. Unfortunately, the medications with less side effects that are not so onerous for patients to receive are expensive and often restricted in certain managed care pharmaceutical formularies.

We believe that a lifting of these restrictions would enhance the doctor/patient relationship and enhance compliance and avoid situations where coercive treatment is necessary.

We believe that mental health parity will improve access to care and, again, improve the ability of patients to receive care prior to severe decompensation.

In point of fact, managed care criterion for admission often require the kind of dangerousness criterion that you see in the current Mental Health Procedures Act. What if we were to liberalize the ability of patients to receive care without changing the Mental Health Procedures Act? In other words, what if we were able to get people to hospitalization who want the hospitalization prior to their behaving in a dangerous way that the managed care company can agree is a reasonable reason for them to have admission?

This is something I don't have to deal with in the VA system. We do not have as restrictive kind of management of care. I can hospitalize patients more freely than I was able to when I worked in the private sector. So these are some of the ways.

Another thing, in my work at the VA Hospital I work in a clinic that is called the Intensive Case Management Clinic. We take our very sickest schizophrenic and bipolar and other

chronically mentally ill patients and we assign them to a case worker that meets with them at least once a week, helps them manage their medications, their pill boxes and so on, checks on them. I found that we have been able to both prevent hospitalization when deterioration was occurring or promote hospitalization without commitment when a person was deteriorating.

This has been a very cost effective clinic for the VA to run. I don't have the numbers in front of me, but I know that there has been tremendous cost avoidance for the VA by instituting a program that is a little more expensive on the outpatient end, but has reduced hospital days and has reduced the need for commitment hearings and so on which are also costly and time consuming for both physicians and people in the legal system.

So with these recommendations and opinions, I now want to answer any questions that you might have regarding the Pennsylvania Psychiatric Society's stance toward this bill.

CHAIRMAN MAITLAND: Thank you very much, Dr. Fisher.

Any questions?

REPRESENTATIVE STEVENSON: Not yet.

CHAIRMAN MAITLAND: I have a few for you.

MR. FISHER: Okay.

CHAIRMAN MAITLAND: This act has been in a large way a change since it was put in place in 1976. There has been, of course, an enormous change in the understanding of treatment of mental illness and the number of medicines available to treat it and other kinds of therapy.

You say this bill goes too far. Do you see any change to the act to take into account the changes that we have seen over the last 25, 26 years?

MR. FISHER: I think what you are saying is how can we get people medications and treatments that they're currently unwilling to take. And part of why they are unwilling to take it is that they are mentally ill. And the assumption, I believe, that you have and the proponents of this bill have is that if you can treat the mental illness the insight will follow.

There is some truth to that. But I think that what I see as problematic about that assumption is that a desire for self-determination is something that the mentally ill and the

nonmentally ill wish for. And I don't believe the assumption that a refusal of treatment is necessarily an indication of mental illness. I can more powerfully get a person to treatment by working with them as opposed to coercing them.

I have seen it all too often that I have had to commit a person -- and, granted, they were committable under the current Mental Health Procedures Act. I would get them better, they would agree that they are thinking better; but they would leave and stop their medications because they were angry at the process. They felt coerced.

It wasn't clear to me that that was, that anger over the coercion was, secondary to mental illness. They may have not had the insight that they needed at the time. They also may have suffered tremendous side effects.

I have been in practice for over ten years, and there has been huge changes. When I first started in training which was in the mid '80s, these anti-psychotic medications were quite onerous to take, filled with side effects. And it's not clear to me that it was necessarily an indication of mental illness when a patient refused to take a medication that caused tremors, twitches of their

mouth, stiffness, drooling.

I guess I am in favor of anything that promotes the doctor/patient relationship. And I'm leery of anything that can undermine that.

CHAIRMAN MAITLAND: Having had the benefit of sitting through a previous hearing and getting a lot of testimony, it seems to me that generally speaking we are talking about two different classes of patients.

We are talking about, on one hand, the class of mentally ill patients who understands or at least has the capacity to come to the understanding of their illness and the need for treatment. And then is the classifications that we are really trying to address with this legislation, the ones that are so sick and don't know it, or they get medicated and start to feel good and think they don't need their medicine. And this becomes a predictable pattern of deterioration.

The literature all says that if you let them go without being treated, you lengthen the amount of treatment they need, you probably lessen the amount of functioning that they can recover. And it seems to me that if we don't make a change like what's being proposed here, that we are failing

really the families and the patients.

MR. FISHER: You know, I would have to agree with you from a scientific standpoint that the data is very clear when a bipolar patient is allowed to relapse in mania, the ability to treat that next manic episode is compromised and can often require greater medications. There is no question that science is in favor of getting people to treatment who need it, the very severely ill.

Again, my concern is the vagueness and the potential threat to patient autonomy. One other concern that I didn't mention in my testimony but had occurred to me as I read the legislation was that a person who is mentally ill, who knows it, might nevertheless avoid getting treatment because they would think that a future behavior that they may have might be interpreted as a prediction that they are going to get sick and that they might lose rights and freedoms. They might be manipulated by not so well intended people. So they might never ever seek care.

This is a tremendous fear that people have currently that are mentally ill. There is a belief that once defined as such you will lose all rights and privileges in any event. So that's

another concern I have, by legislation that's vague and open to interpretation, how many people will suffer in silence as oppose to seek care.

CHAIRMAN MAITLAND: The act says that treatment on a voluntary basis shall be referred to involuntary treatment, and in every case the least restrictions consistent with that of treatment shall be employed. And we are not going to change that.

And then it says that treatment may include inpatient treatment, partial hospitalization, or outpatient treatment. But outpatient treatment really isn't an option to people under the current law, because if they are to the point where they are an immediate threat to themself or others, they are not candidates for outpatient treatment.

So under this proposal, you can more easily get people into outpatient treatment where they would perhaps have more of a sense of self-determination than they do with the current statute.

MR. FISHER: Let me say that I am now taking off my hat representing the state and tell you my own personal views about outpatient commitments. And, again, I want to say that this is

my own personal view.

CHAIRMAN MAITLAND: Okay.

MR. FISHER: I think outpatient commitment has the potential to be a very powerful tool in keeping people from requiring hospitalization and from getting to the point where they can be 302'd for dangerous behavior.

The problem I experience is that current outpatient commitment laws are basically a paper tiger. They are only as effective as the patient's belief that they are effective. In point of fact, if the person refuses to show up or take their medications and they are on an involuntary commitment on an outpatient basis, there is very little that I can actually do to enforce it.

It may be that rather than changing the whole Mental Health Procedures Act, attention to the outpatient commitment statutes and provisions might be a way to go and could that be an area where a more liberal interpretation of deterioration could occur. Now, even having said that, I'm not sure that this bill -- let's say this bill was limited to outpatient commitment, these amendments. It's my view that they may still be too liberal in interpretation or lean too heavily against patient

self-determination.

But I do agree with you that I would like to see outpatient commitments have some teeth because they currently don't.

CHAIRMAN MAITLAND: I've seen in New York they enacted a law called Kendra's Law. And some of the statistics on the improvement in the number of patients that are medicated, they are not homeless anymore, suicides are down, criminal convictions are down.

MR. FISHER: That's right.

CHAIRMAN MAITLAND: That's where we are trying to go with this.

MR. FISHER: Right.

CHAIRMAN MAITLAND: You talked about your intensive case management that you do.

MR. FISHER: Yes.

CHAIRMAN MAITLAND: Is any of that court ordered?

MR. FISHER: Yes. In many cases we're talking about outpatient commitments, so they are committed to the outpatient treatment.

Now, the reason they work quite honestly is that the patients don't understand how little power the commitment really has. They

believe that if they don't comply with the outpatient treatment that that necessarily means hospitalization. In point of fact, that isn't how these laws actually play out.

They can get people to their appointments if they don't show up. But, again, that's contingent on being able to finance the case managers and go out and look for them and so on.

Again, where I see the problem isn't so much in changing the law in terms of access, but changing the financial status of the mental healthcare centers that have intensive case managers, lessening the case managers' caseloads because they have huge, overwhelming caseloads. The caseloads that we have at the VA are very reasonable for our case managers to manage.

That isn't the case -- I know how we differ from the county mental health centers. And it's possible for the case managers I work with to actually be Johnny-on-the-spot on top of things with the patients. I don't think it's true as much in the mental health centers.

CHAIRMAN MAITLAND: I agree with your suggestions about the drug formularies and the mental health parity and things like that. I'm not

so sure about the advanced directives. But they are not in the purview of this committee.

MR. FISHER: Actually, the advanced directives, I believe, was from someone else's testimony.

CHAIRMAN MAITLAND: Right. Another hat I wear is I chair the Crime and Corrections Subcommittee of the Judiciary Committee. And some of the statistics I've been reading suggest that 16 to 20 percent of the inmates that are in state prisons are mentally ill. And, again, if we can get them to treatment.

MR. FISHER: I recently a few months back testified on the issue of mental health courts, the idea of it being a diversion of the mentally ill who are incarcerated to appropriate care as opposed to incarceration. And the State Psychiatric Society very much supports that legislation. At the point of incarceration, we would certainly like to see a very quick movement of the mentally ill from the prisons where they are not going to get appropriate care to mental health facilities. We support that wholeheartedly.

I think where we differ is this idea of preventing the event from occurring, not because

we don't want to prevent it from occurring because we do, but we see a leaning away from self-determination for the patients, and a discrimination, in a sense, against the mentally ill's rights.

CHAIRMAN MAITLAND: I just have a couple other comments.

MR. FISHER: Sure.

CHAIRMAN MAITLAND: You mentioned that perhaps the terms are not defined in the act. Actually, they are legal terms of art, like cruelty to animals is in the Crimes Code, Title 18. So a judge would have access to the definitions and the legal terms such as predictable deterioration, totality of circumstances. But like you, I'm not a lawyer, one of the few on the Judiciary Committee that's not a lawyer. I am aware that those terms are defined elsewhere in law.

You had mentioned that there are circumstances where it would seem reasonable for a patient to stop taking their medication. As a physician, do you want patients making that decision? I mean, wouldn't it be ideal for them to come to you and say they are having problems with their medication and you would adjust it?

MR. FISHER: Absolutely. That's the ideal. My concern is that that dialogue could be hampered by their sense of being coerced into the treatment. I also have concerns, you know, physicians while very well intended can make mistakes, can be overwhelmed with a high volume of patients and not necessarily pay attention to side effect concerns.

It's not my intent to malign my colleagues or suggest that in any way I or other psychiatrists are incompetent, but mistakes can happen. And often it's the patient's refusal to treatment that can be the wake-up call, hey, maybe we did make a mistake. I guess that's my concern.

In a busy practice where a physician might be able to not listen as carefully to the patient's concerns or to be able to say, you know, I've heard this all before. This patient has refused medications because of their illness and go ahead and treat it in a more coercive manner, might they miss an actual legitimate concern of that patient.

These are my concerns.

CHAIRMAN MAITLAND: I guess my last question -- maybe you're not the right one to ask --

is you mentioned that we can't force treatment on other people unless they have been judged incompetent. What does it take in the case of the mentally ill person to get them legally determined to be incompetent?

MR. FISHER: That's a very good question. The assumption of this bill is that refusal of treatment or certain behaviors that have been predictive of deterioration might be evidence of incompetence. I'm not sure if that's true. My sense is that that's a sweeping assumption.

And, again, that's where our oppositions of this bill lie.

CHAIRMAN MAITLAND: It might be and it might not be. The bill gives the authority to the judge to look at the totality of the circumstances and past behavior to make that decision.

MR. FISHER: That's right.

CHAIRMAN MAITLAND: Thank you, Doctor.

MR. FISHER: Sure.

CHAIRMAN MAITLAND: Representative Stevenson.

REPRESENTATIVE STEVENSON: Thank you, Mr. Chairman.

CHAIRMAN MAITLAND: You're welcome.

REPRESENTATIVE STEVENSON: Thank you for your testimony. It was very informative for myself. I want to go back to something you said initially. Really what it comes down to is a balancing act of, I guess, society's need to get these people treatment versus the right of that patient's self-determination.

In the end, which should be given more weight?

MR. FISHER: Psychiatrists are excellent at side stepping questions. This is one of our skills. It's required in numerous clinical interactions, so this may seem like that.

The most powerful tool I go back to that, in helping to protect society from dangerous behavior of the mentally ill is not a coercive stance which is in a sense a kind of incarceration although it's a kinder incarceration. It's an incarceration in a mental health facility with the idea that in a paternalistic way we will help this person get better and help them.

That paternalism and that coercion can undermine the therapeutic relationship, which is truly the most powerful tool to keep the revolving door from occurring and to promote treatment.

In that sense, I guess I will answer your question and, that is, that probably the self-determination is more important. Why is that? Because, ultimately, that's what's going to get the person the necessary treatment.

REPRESENTATIVE STEVENSON: Isn't it true that if society's need to get that person treatment really shouldn't be given more weight you wouldn't have a job, in a sense? I'm trying to get you turned back around. I disagree with you, obviously.

MR. FISHER: Right. But there are criterion. I mean, they're very clear criterion, evidence of dangerousness. And that can be interpreted in a somewhat liberal way as well. I mean, I have involuntarily hospitalized people who have touched me or have touched another person. That was a kind of battery. And it was movement toward a more aggressive stance.

Threats, verbal threats, verbal threats to harm oneself or others. I mean, there are very clear and somewhat liberal criterion to get a person into involuntary treatment.

All too often what has prevented a patient from staying in a hospital after they have

been 302'd has been the refusal of the person who committed them to begin with to show up at the hearing.

I've also been witness to, even under the current Mental Health Procedures Act, abuses of this act where angry and disgruntled family members have coerced a person into the hospital because they wanted to get a hold of their money, because they wanted to manipulate them in some way. I have seen that numerous times.

While the legal system in place is there to protect the patient from those abuses, and it does, on a 302, that's five days. That manipulative family member could deplete that person's bank account if they have a joint account during those five days. There is potential harm done to the person who isn't suffering from a deterioration that could lead to aggression, but who has been manipulated by a person who has 302'd them.

And it's a judgment call of the person who is manning the telephone for the County Mental Health Department to determine if that person should be committed or not. And it's been my experience that the fear and concern about allowing a potentially dangerous person to go free far

outweighs the decision to let them leave at that point, as it should.

I think a judgment call that is made at that step tends more often to lean in favor of 302 commitment. I think that's okay. I guess what I'm saying is that I think, given the balancing act that's needed in this, that we have a pretty good Mental Health Procedures Act and that beefing up other aspects of mental health treatment is what will accomplish the same goals that the people that have proposed this bill or suggested it want to achieve.

REPRESENTATIVE STEVENSON: Thank you.

CHAIRMAN MAITLAND: I have one more question that occurred to me.

MR. FISHER: Sure.

CHAIRMAN MAITLAND: The 30-day medical history, is that long enough for the court to consider in these proceedings?

MR. FISHER: That's an interesting question. I think that's a huge, huge judgment call. You know, in terms of response to treatment, it can take one to three months to see an actual response in medication or nonmedication treatment for a person. So the 30 days, is that clinically

relevant or not, that I don't know.

I guess your question is if a person has threatened somebody 60 or 90 days prior, could that be useful. The problem I see in that is if they were mentally ill 60 days ago and not mentally ill 30 days ago, but they are in a conflict with somebody who wants to commit them, could that 60 days be used against them. The same with 30 days. There is a certain arbitrariness to that decision.

I really have a hard time saying what the right thing to do in this case would be.

CHAIRMAN MAITLAND: Thank you.

Mr. Schwoyer.

MR. SCHWOYER: Thank you, Mr. Chairman. Thank you, Doctor.

First, you talked about the mental health courts and you testified previously in that area and you said society produced legislation, and you refer to authorize use of mental health courts to divert people from the criminal justice system to mental health treatment arena.

MR. FISHER: Right.

MR. SCHWOYER: The problem that I have with that is -- a little bit of background on me. I was a prosecutor for ten years before I came to work

at the General Assembly. My problem with that is that the crime has already allegedly been committed, somebody has been hurt, damaged or injured at that point in time. And to excuse conduct because of a mental illness at that point in time, I'm not sure that I understand that.

This bill is an attempt to, as you said, prevent the conduct from occurring in the first place. Likewise, with the use of the mental health courts and from what I know of the courts, they seem to be a wonderful and available tool and it's something that the committee has had me looking at to get more information for them. But there's also the district attorney and the police involved at that point and a victim who has been harmed. My guess is it makes no difference to the person whose property has been damaged or who has been assaulted, punched in the face, feels the same whether a person has a mental illness or not.

So to say that we don't need this because mental health works in a better way, I'm not sure they address the same sort of conduct. That was the problem I had with some of your suggestions, the five suggestions, in your testimony. I don't know that any of them address the concern that this

bill addresses.

MR. FISHER: The bill clearly intends to address prevention of dangerous behavior that might occur secondary to mental illness. I think the goal is admirable. The concern that our society has is that how many people will wind up with the burden of involuntary hospitalization or commitment who ought not to be.

MR. SCHWOYER: But we can't forget that the law currently contemplates involuntary outpatient treatment or partial hospitalization. I find that the onus of this legislation always talks in terms of the most extreme, severe, forced compliance authorized which is -- that's scary is involuntary hospitalization. But there's also a provision for an involuntary outpatient.

MR. FISHER: Well, there are serious consequences, unfortunately, and, again, this is something that I would like to see changed. There are very serious consequences to a diagnosis or, quote, label of a mental illness. A person who has been diagnosed with depression may not be able to obtain life insurance or may have very expensive life insurance.

An involuntary commitment, whether

justified or not, may prevent that person from being able to purchase firearms. What if they live in a rural area where that is something that gives them a sense of safety. They can't do that legally. There is a duty or a desire that we all have to protect society. But we also protect society when we do not force people and coerce people into certain things inappropriately, we protect our individual freedoms.

MR. SCHWOYER: Those concerns, though, I guess are concerns with the existing law because the medication compliance presupposedly diagnose and prescribe medication, so the label's already been applied, those consequences have already been felt.

MR. FISHER: But that may have been a person who voluntarily sought treatment at one point in their life. And now because they have been diagnosed with a mental illness, somebody is saying, oh, you're just crazy, when in point of fact what they want to do is manipulate the mental health system to harm that person. That can occur. It occurs under the current mental health procedure law. I see it all the time. This would only make that more common.

I understand the balancing act. We

need to -- when a murder occurs because somebody has been mentally ill, it's a horrible thing. I think we all tend to say, let's liberalize the capacity to commit people because protecting society is the more important issue. We see that right now in terms of what we're doing with immigration laws and so forth. We have flipped the other coin.

It's always a balancing act. But if we lean too far, I believe that the mental health courts will be inundated, the hospitals will be inundated. There won't be meaningful changes in terms of managed care, so that you're hospitalizing all these people who insurance companies aren't willing to pay for. You're creating circumstances where patients feel that their relationships with their physicians and their relatives are adversarial.

MR. SCHWOYER: You made that statement before. I was trying to figure out in my mind how you can make that statement regarding relationships, yet you said that the court-ordered involuntary treatment works because the patient thinks if they don't abide by the court ordered treatment, then there is going to be more severe penalties.

MR. FISHER: It only works with those

folks.

MR. SCHWOYER: Looking through your things, No. 5 is for drug formularies, expand them. I'm not sure how that would help.

MR. FISHER: Well, a person may be noncompliant because they have severe side effects of the older anti-psychotic medications, so at some point they are involuntarily committed. Then maybe they are actually committed on an outpatient basis and they are receiving these medications by monthly injections. They are never afforded the opportunity to refuse that and never afforded the opportunity to get on a newer, more expensive anti-psychotic medication. So now this person is forced into treatment that is going to give them a long-term motor disorder that can be quite disabling.

The other issue about the restricted formularies is that what happens when you have a formulary that makes a physician leap through so many hurdles and even after that refuses to allow them to prescribe a medication that doesn't result in these side effects.

I mean, the issue of access to care is, from my vantage point, less about the patient refusing the treatment than it is about the same

society that would like to get them away and protect themselves from safety, is also the same society that is not willing to pay for the expensive treatments that help keep them out of the hospital.

MR. SCHWOYER: I understand that. We heard lots of people talk about the need for more funding, which is very much related to the issues in House Bill 2374, yet probably more appropriate for Appropriations or Finance or Health and Human Services.

MR. FISHER: But without it, this is incarceration.

MR. SCHWOYER: I understand that. But who is to say that that isn't something that another committee is dealing with if the funds were there. If the formulary -- if mental health parity was the law in Pennsylvania, the managed care issue is reformed --

MR. FISHER: This is a philosophical debate on society's capacity and right to coerce and remove individual rights. It becomes more of, I think, a legal governmental philosophical debate than it does a mental health debate. I agree with you, it is desirable to prevent dangerous behavior before it occurs. I also think it's desirable that

people have as much freedom and self-determination as they can possible have.

What's the best balance? We think that the Mental Health Procedures Act of 1976 took those considerations into account and did well with balancing that, and that we can improve that balance not by changing legislation but by improving access to care. Will there be cases, though, where a dangerous event will occur that we wish we could have prevented? Absolutely. It will happen.

It's always a balancing act. That's the debate going on regarding immigration laws right now and preventing terrorism.

MR. SCHWOYER: Do you ever get phone calls from family members or friends or acquaintances from persons suffering from serious mental illness who say, Mike is -- I don't believe he is taking his medicine. I found three months worth of prescriptions on the floor of his car. Mike is again talking about how he's going to make lots of money at the racetrack. I don't think he's been into work. What can I do to help?

What do you tell that person? As soon as he started to hurt you or someone else, let me know.

MR. FISHER: Now, if they are on an outpatient commitment and that were strengthened in some way, one of the requirements is that they show up at appointments. If they fail to do that, you can bring them in. That's -- believe me, that will have happened by the time that they are starting to deteriorate in the way that you've described.

MR. SCHWOYER: How do you get that outpatient committed based upon the evidence in the scenario I just stated?

MR. FISHER: Well, what will happen is a consequence of repeated prior 302's and 303's. That is true. But doing it any other way, in our opinion, in the Society's opinion, is leaning too far toward coercion. And from a clinical standpoint, clinical, I know that that isn't in my patient's best interest.

MR. SCHWOYER: Representative Maitland read from the beginning of the bill. I'm now reading from the end of the bill where it talks about the time frame. The involuntary commitment shall not exceed 90 days. It talks about their full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the

person's relationship to his community and family, his employment possibilities, all available community resources. Chairman Maitland wishes to add medication compliance and guardianship services.

If all of those things are fully considered, isn't that where -- if a patient is not taking it because of money or maybe alternative medication available, that that behavior is not necessarily consistent with the decompensating mental illness, isn't that how this whole thing works?

MR. FISHER: Let me show you another perspective on this. Let's say that a psychiatrist in a mental health interview determines that a lesser level of care than involuntary inpatient commitment is needed, testifies to that, and the person goes out and nevertheless behaves in a dangerous way. Don't you think a psychiatrist would want to protect himself from that liability risk, that potential malpractice suit? The point -- the details aren't in what is clinically right at the time. We're swayed by all sorts of things, too, like potential risk and liability.

Nine times out of ten, if we think a person wouldn't act in a dangerous way but were not

100 percent sure -- maybe I'm speaking only for myself, but I would probably go with the most restrictive because I don't want to take the chance of danger.

I think that's what motivates this legislation and I understand that. You want to protect people. But when we do it through laws, there's a very strong potential danger of limiting people's rights.

MR. SCHWOYER: Thank you. I know that I get adversarial. It's very helpful.

MR. FISHER: That's fine.

MR. SCHWOYER: It helps to ask these questions. It helps to know your perspective.

CHAIRMAN MAITLAND: Jane.

MS. MENDLOW: Dr. Fisher, you mentioned that it was very important for a patient to develop trust with the doctor and that that's probably one of the main ingredients in successful treatment.

I want to see if I understand. If the situation where you have an individual who may not have had an encounter with the mental health system or even with the criminal justice system but seems to be exhibiting a very marked change in behavior

that's noticeable by everyone and community and professionals, explain to me how you feel that the legislation, again, undermines the issue of trust. The way it's written right now, it talks about identifying a person who didn't have the capacity, does not have the capacity, to make a rational treatment decision.

I guess what I'm trying to understand in a situation where someone perhaps does not have any previous involvement but suddenly has because of some drugs that are issued -- you know, it's not always possible, I suppose, to look at the issue of trust. Sometimes there has to be some intervention before. So we have a situation sometimes where you have had a longstanding history with the individual and others where there has not been any contact before. I would like to go back to this issue of trust.

MR. FISHER: Excuse me. Could I respond to that?

MS. MENDLOW: Sure.

MR. FISHER: It sounds like you are going on to another issue. I want to respond to the issue of the person who is clearly exhibiting mental illness, poor judgment, unusual behavior and has

never been in the system before. How do we know that that unusual behavior is going to lead to dangerous behavior? The only basis for that would be prior treatment, prior involuntary hospitalization.

MS. MENDLOW: Right.

MR. FISHER: It's a right and a privilege for a person to be eccentric, to do unusual things, as long as they are not harmful to somebody else or others.

MS. MENDLOW: Okay.

MR. FISHER: Now, if they are dangerous, okay, we have defined it. And the Mental Health Procedure Act as it exists now addresses that so that first time break can be hospitalized. But if the person is suffering from a mental illness without harming anybody, or a nuisance maybe but they are not harming anybody, is it right to force treatment to assume that they will become aggressive?

MS. MENDLOW: If they were delusional and not in a situation where they are making rational decisions, how can we talk about issues of trust at that point when a person --

MR. FISHER: As far as I understand it

from the case you are giving, that's not even the issue. They haven't even entered into treatment. If the intent of this is to take anybody who is acting in an eccentric, unusual way or even if they have been diagnosed mentally ill and are not dangerous now and are forced into treatment, that's a very, very dangerous treading on people's individual rights.

MS. MENDLOW: One more question. You mentioned that there are situations you see where family members are trying to exploit an individual who is mentally disabled, and you are very concerned that while this person may need to undergo some type of treatment, the family members will take advantage of their assets or make decisions that will wind up detrimental to the patient.

Can you tell me whether you or others would like to recommend to ensure the protection of people from this exploitation? It borders on criminal behavior but what can the mental health system be doing?

MR. FISHER: That I don't know. It's obviously criminal behavior. But one of the reasons that we are discussing this matter is that the mental ill aren't able to make decisions for

themselves. I mean, in other words, that person's funds can be long depleted. We need to protect their interest. It would be better if we could protect them of the harm.

MS. MENDLOW: Some type of a guardian to ensure this person's property or assets are protected while under treatment, is that what you mean?

MR. FISHER: Yes.

MS. MENDLOW: Just the issue of treatment and your frustration with formularies, etc., are these rules set by the Department of Public Welfare or the Department of Health and Human Services?

MR. FISHER: The Department of Welfare in consultation with all sorts of experts.

MS. MENDLOW: Thank you.

CHAIRMAN MAITLAND: Thank you very much for your testimony, Dr. Fisher. It was very informative and very interesting.

MR. FISHER: Thank you for the opportunity.

CHAIRMAN MAITLAND: As usual, we are running late. We will ask the next testifier, Mr. Richard Jevon, to come forward.

MR. JEVON: I, too, found that interesting. I thank you very much for the opportunity to testify.

My name is Richard Jevon. I'm here testifying as a private citizen, even though I am a very active volunteer and serve on boards of several organizations whose missions are directed towards helping people and families who are affected by serious mental illness. I'm a retired businessman, 34 years with Alcoa, 2 years with Allegheny Valley School and 7 years with SMS Engineering.

My wife and I have two sons. The older son is 45 years old and has suffered from paranoid schizophrenia for about 27 years. He has been involuntarily committed to a mental hospital somewhere around 25 times. I lost track. For the most part, I was the petitioner for at least 20 of them. So it's sadly that I have become a lay expert on 302 commitments.

We spent about the first 10 or 12 years as a family just coping by ourselves. And in 1987, I came out of the closet and began to educate myself and others about the ravages of mental illness and its impact on families. The first thing I did was to read the 1976 Procedures Act on

commitments because I thought it should be easier to commit a sick person.

Then I read the case law on the subject. I began to believe that the law was a pretty good balance between enabling the system to commit for observation and treatment and protection against abuses such as getting rid of obnoxious, troublesome family members.

Remember, this was the era of Haldol and Stelazine, and I had no real clue about the impact of the meds or their side effects. I just knew that the meds and the commitment calmed things down and provided temporary peace. I did not know about the side effects of these meds.

The next 15 years have afforded me an enormous learning experience about serious mental illnesses, our public system of behavioral healthcare including the managed care as developed in southwestern Pennsylvania. I learned that interpretation and administration of the Procedures Act varies widely across the state. Interpretations of dangerousness vary considerably, and the passive harm to self is not widely understood or used. It is a very important concept.

Some of the things that I have learned

along the way include that until the person with serious mental illness understands that they have an illness and decides to cope with it, they cannot be forced to treat it. To the uninitiated, forcing treatment generally means making the person take an anti-psychotic medication.

However, treatment is much more complex than taking pills. Different people and different diagnoses respond differently to different medications. Some diagnoses do not yet have a proven effective medicine. In addition to medication, a wide array of treatment, service and support actually define treatment. Effective use of any and all of these vary from person to person. Mandating treatment is meaningless, unless it is tailored to the individual and the individual buys in. Mandating treatment would also assume that the full array of options is available to each person suffering from serious mental illness.

Sometimes people with mental illness know that their symptoms are getting worse but, because of the symptoms, they cannot do what they know they should do. Illustration: Symptoms are worse and the individual knows it but can't go to clinic or can't take meds or just act out. Many

times, in these circumstances, a change in environment will enable return to the stabilizing regimen. At times like these, a commitment to a structured environment is the trigger needed to enable the individual to resume treatment.

It is a very different circumstance when a person is experiencing a first or second episode compared to a tenth or twentieth. Mental illness tends to be episodic, and symptoms can moderate and then become exacerbated. Various environmental conditions such as stress, change in living arrangements, irregular eating can lead to one or the other condition.

I think both commitment and treatment should recognize whether or not the illness is new or a return of previously experienced symptoms and behaviors. As an illustration, a family member of a suicidal consumer recently reported verbal behavior similar to that which preceded numerous previous actual attempts, but the individual had not yet actually done anything in furtherance. To me, history strongly suggests the need for commitment and evaluation and the presentation of treatment options. However, forcing treatment is really a second issue.

When is a person considered dangerous? In recent years, there has been considerable research into violence and mental illness. Dr. Edward Mulvey of WPIC has been very involved in such research. I refer you to experts such as Dr. Mulvey, but I believe he will say that accurate prediction of violence is not possible.

However, based on our family member's history, I think that history and the totality of circumstances are excellent and reliable indicators of the need for commitment and evaluation. In essence, the commitment is also for assurance of an environment conducive to treatment but stops short of restraining an individual and forcing medication.

I also acknowledge that a confined environment for a person suffering severe paranoia will be controversial and objected to by many. I know of one individual who has lived on the streets for years and does and would vehemently object to commitment. In his case, the totality of circumstances and history does not reveal danger.

Some of the specifics of House Bill 2374: Section 102, I see deletion of the need is great and its and the insertion of treatment as minor changes clarifying intent. I have no

objection.

Section 104 I am concerned about the insertion of to protect a person from predictable deterioration in two places. The issues are who does the predicting and what is the role of the individual's history. Without further identification of the individual making the prediction, there is no assurance of the validity of the predicted deterioration. For first or early episodes, prediction can only be based on large data base information and may not be at all applicable to the individual in question. On line 12 of what I think is page 2, insertion of or maintain is good.

Section 301, identification of persons who may be subject to involuntary emergency examination and treatment. Three issues are embodied in person or with cruelty on an animal, or that the person has intentionally caused significant damage to substantial property of another person. Person is simply clarifying language. Cruelty on an animal is objectionable to me. I'm aware that this is a danger signal for children, but I don't recall its being a symptom of any serious and persistent mental illness. I am an animal lover but suspect this would be a manifestation of some other behavior

problem.

Intentional significant damage to substantial property of another person is a problematic statement to me. There could be situations in which the damage is not significant but the behavior fits the need for commitment. Conversely, the causing of damage is not necessarily a manifestation of mental illness. I would rather stay with the dangerousness to self or others including passive danger.

Deletion of threats of harm and has committed acts in furtherance of the threat to commit harm is good with the insertion that follows. Insertion of one or more threats of harm and the totality of circumstances supports a finding of danger is good. Still in 301, Section (2)(i), deletion of physical in the description of serious debilitation is good.

Insertion of new Section (2)(i) is not good. It is the forced medication issue and there are several ramifications to this. What is the medication? Is it the cheapest? Has the individual ever satisfactorily used the medication before? What are the side effects? And, finally, there is the issue of individual freedom. Many cases would

be satisfactorily resolved if the individual is committed and sheltered in an environment conducive to treatment and if the treating personnel have the time and ability to persuade the person to try the medicine.

Changes to Section (2)(ii) are good. Deletion of threats to commit suicide and has committed acts in furtherance of the threat to commit suicide, followed by the insertion of one or more threats to commit suicide and the totality of circumstances, supports a conclusion that there is a risk of a suicide attempt, is good.

I forget which one of you folks asked about phone calls. I volunteer many hours each year and we get calls. And within the past month, I was talking to a young woman, a master student at PIT whose mother has a history of suicide attempts. She was saying the things she had said at the time of the previous attempts but she had not committed an act in furtherance. I think it's important to look at the totality of circumstances and, there again, history to me would be very, very important there.

We do get a lot of calls. You asked about calls from people. What do I do? There is no magic answer. Those are tough calls. We get them.

We do get calls like that all the time.

Section 304, medication compliance. I would say that that's the major cause for our son's repeated hospitalizations. I find it very difficult to think about restraining him and forcing the medication. The doctor referred to the injectables. We have had pretty good luck in the past 15 years with his medication because it was an injectable and we worked out an agreement where he would get his meds or else I wouldn't buy him cigarettes. Sounds kind of elementary and crude but it worked. We are kind of beyond that now. Just to put flat medication compliance, how do you know? Do you count the pills? Do they take them? Do they throw them out? People with mental illness are not by definition dumb. Our son is quite smart. They can figure out the system.

In summary, I do believe there are some fundamental flaws in House Bill 2374. I do believe forced treatment does not work. It can afford temporary rest, but the treatment leading to recovery does require participation by the consumer. Forced medication treatment, I think, is a proposed quick fix for a system that is deficient in outreach and the full range of support, including clinical

accountability for clients.

I believe that permitting an individual's history and totality of circumstances to be considered would enable people with serious and persistent mental illness to access earlier when their symptoms are exacerbating.

Thank you. I would be happy to carry on discussion.

CHAIRMAN MAITLAND: Thank you for your testimony, Mr. Jevon. I particularly liked you going through it section by section making recommendations of things you like and didn't like. That's helpful to us as we go along.

Are there any questions? Representative Stevenson?

REPRESENTATIVE STEVENSON: Not at this time.

CHAIRMAN MAITLAND: Mr. Schwoyer.

MR. SCHWOYER: Thank you for your testimony. I don't have any questions because, as Chairman Maitland said, your section by section explanation of where you are at helps a lot. I was commenting to Chairman Maitland during your testimony that I'll take another look at the language on top of page 5, because I wasn't reading

that as medication, forcing medication compliance language.

MR. JEVON: That's an interesting view of the elephant. People in the office always kid me and I say, what view of the elephant do you have?

MR. SCHWOYER: I'll take a look at that. Do you have the language bill in front of you?

MR. JEVON: Yes.

MR. SCHWOYER: On line 4, if there was a period inserted after the word days and the remainder of that line were struck, would that make it better or worse in your opinion?

MR. JEVON: Give me a moment, please, to read it.

MR. SCHWOYER: Sure.

MR. JEVON: I think what you are suggesting is that if that paragraph or section read only if the person acts in such a way as to evidence the person does not have the capacity to make rational treatment decision, and serious physical or mental debilitation would ensue within 30 days. On the surface, I would say that's a great improvement, but I'd want to back up and see what the precursors to that would be.

MR. SCHWOYER: Okay.

MR. JEVON: It's certainly an improvement. Whether I would then say, no, I don't object at all, I need to go back and see how it gets set up by the prior sections.

MR. SCHWOYER: If you have an opportunity to think about that, I would appreciate your thoughts.

MR. JEVON: I would be happy to.

MR. SCHWOYER: Thank you.

MR. JEVON: You're welcome, sir.

CHAIRMAN MAITLAND: Ms. Mendlow.

MS. MENDLOW: No.

CHAIRMAN MAITLAND: Thank you, Mr. Jevon. We really appreciate your testimony.

MR. JEVON: Thank you very much.

CHAIRMAN MAITLAND: Next we have Mrs. Susan Meckley attending with us today. She traveled the furthest today. She traveled about 15 miles further than I did.

MS. MECKLEY: Good morning. I certainly appreciate being here.

I heard the words being forced used pretty much in everyone's testimony this morning. I would like you to keep that word in your mind as you

listen to what I would like to testify to.

Our situation has been going on for 14 years. And I'd also like to say that our situation deals with how a mentally ill person has affected the life of our daughter. Some people call it stalking but because he is mentally ill -- and that's why I am here -- I would like you to keep that in mind.

The testimony that I provided gives pretty much everything that I brought with me today, except possibly those who had the testimony given earlier do not have the last page.

When I tell you for 14 years this has been ongoing, I would like you to look at the last page which is dated July 26th, 2002. This would be our last letter from this man. If you don't have it, it's over in the new copies that I brought today because it was just sent to us. We received it two days ago. This is proof of what I'm trying to tell you can go on and on and on, what you might think is one little letter or two little letters or a year out of your life or two years out of your life. I would like you to look at the broad scope of this 14 years to the date of July 26th, 2002.

Our daughter was friends to a young

boy in her school. We did not know at the time that this boy had a mental illness. We thought she was just being kind to a boy that didn't have very many friends, couldn't make many friends, and didn't get along well in school at all. We admired her for this.

Sometime later this boy turned her friendship into what he thought was a love affair. He came to visit our homes many times. My husband took him home. We befriended him as well.

Sometime later, my brother contacted me with the fact that he had been given a threat by this young man. He at the time didn't know who he was. He also put together the threat and the letters he had been receiving demanding money, prestige. This man looked up to people who he thought were in power, who he thought had money and he deserved it. And he wanted to use the people that had it to ensure the fact that he would get it.

My brother came to our house and our daughter came down and said, I know that handwriting. We took it to the police. The police brought this young man and his family in for an interview. We could have pressed charges. And I don't mean to be condescending, but we did feel

sorry for them. And this is no offense on previous testimony. I don't mean this is where you're at. But we did have sympathy for this family and we felt for them so we did not press charges.

This family said that they would keep us in contact, what his progress was, where he was, that they were seeking treatment for his schizophrenia, that he would be committed as soon as possible. All this ended the day we walked out of the police station. The parents no longer had contact with us. But it didn't end with this man.

All this time he continues to write letters. As you can read the letters that I have submitted are just a small portion of the many, many letters that we receive all the time. I'd like you to think about what this takes out of a young girl's life, her family's life. I would like you to think about why should she be a victim of a mentally ill person. She didn't ask for this. She showed kindness. All she wanted to be was a good person. But for 14 years this very week, she is still paying for being a nice person.

We are told that if he would stay on his drugs, if he takes his prescriptions, that a lot of this would never have to be. There has to be

some merit in being forced to take medication. We know that medication is a serious part of treatment of the mentally ill as well as it is of the physically ill. How then can we say that not forcing someone to seek medical attention through drugs is not necessary? I don't know how you would implement this. But I believe this has to be at least a root to getting to how we are going to solve at least part of these problems.

It's no use addressing why the law does not come into effect with us. We've dealt with case workers. This young man went on to be committed. We've dealt with his case workers. We've dealt with the mental health people. They speak to us only hypothetically because once you are out of the state hospital, the victims, the people that he is threatening, the people that he's harassing, the people that he's stalking, they are no longer contacted. You are contacted as a victims' list while he's in the hospital. Once he is released to a halfway house, he is then thought to be able to lead his normal life even though his victim is not allowed to lead her normal life.

I still think that this bill would help to at least solve some of these problems that

we have with these dangerously, dangerously mentally ill people.

I also heard the testimony from the doctor on the unpleasant side effects. I heard about rights being taken away, that we can't physically force a person to go into the hospital. But when that person takes away the rights of someone else, then, in my opinion, they would have two choices. They are incarcerated or go to a mental hospital to seek treatment. These would be their only choices.

My daughter, my family, should not have to deal with this the rest of her life to be told to go and seek a new identity, to move out of the state. She shouldn't have to do this. She shouldn't have to be afraid in her own home. We should not have to put in thousands of dollars of security systems to protect her from something she had no part in. The system, the government, has to help to protect these innocent people.

Thank you very much.

CHAIRMAN MAITLAND: Thank you, Mrs. Meckley.

Representative Stevenson, any questions?

REPRESENTATIVE STEVENSON: I'm going to reserve my thoughts. Not at this time, thank you, other than to say, thank you for your testimony because it is exactly, I think, what this bill is trying to solve.

MS. MECKLEY: Yes, it is.

CHAIRMAN MAITLAND: Mrs. Meckley, when we first talked we discussed the possibility of prosecuting this fellow under the stalking law.

Can you tell us a little bit about your thoughts on that and how that developed with you?

MS. MECKLEY: I didn't know how much I was supposed to speak on the stalking law because this is not the bill that takes issue with that. During the course, we have met with many lawyers and personally-paid lawyers, former district attorneys. All the local police know of our daughter's situation and are on the lookout for her.

They've all suggested restraining orders. The restraining orders work to a point where you have someone who can completely rationalize the problem that they are in. In other words, if I do something wrong, I am going to be prosecuted for this; therefore, I'm not going to do

this.

When you are dealing with a mentally ill person who is delusional, who sees figures, who sees red people coming at him, you think about how is he going to make sense of a piece of paper that tells him to stay away from my daughter's home. He isn't going to. So what we are told is the first offense gets recorded. The second offense gets a warning. The third offense might get him 30 days, possibly, not likely. The fourth offense would then probably lead to a 90-day incarceration and/or mental facility.

The mental health people suggest to us that he is still living in the state that he was when he was 16 years old, that he has chosen to stay there because this is a comfortable place for him. He does not recognize the fact that my daughter is married. He still sends her letters to my home, not to her home. She thinks that to send him this kind of letter, this kind of demand, would possibly send him over the edge. And she said, do you want to take that chance that where he is at you can deal with him; where he is going to go, you can't deal with him.

He has made threats. He's made many

threats. Money is nothing. We don't care about the money. It's when the letters come and they say, I've given you enough chances. I've given you enough. This is your last chance. You meet me at so and so or you're going to pay. I'm going to get even. The next paragraph he might say, you are still the love of my life. I can't live without you.

This is where the law is for us. It's no good. They can't arrest him until he hurts her. Is that what we have to wait for because he is going to go -- read his last two letters. He is going to go. He has been without medication. He's been without a halfway house now for almost four years. And the letters are coming constantly. And you can read in his letters as much as they have similarities, they also have an escalation of his problems, of his paranoia, of his delusions. You can read it. You can feel it.

That's where the law is for us. There is no law. He can threaten her. He can demand money. There is no law to arrest him for this.

CHAIRMAN MAITLAND: When we spoke before, you really conveyed to me the sense of how you feel trapped by this.

MS. MECKLEY: Yes.

CHAIRMAN MAITLAND: Can you describe for the panel here a little bit about how you would feel when your daughter would be late or you would not get a phone call?

MS. MECKLEY: Absolutely. When it was time for her to go away to school, we had to look into all the colleges that had the best security systems. We had to find roommates whose parents were willing to let them live with her.

She carried mace with her. She carried a paint gun with her. She went nowhere by herself. We took her everywhere. She was not allowed to go anywhere by herself. We didn't allow it. If she went anywhere, we had to know when she arrived, when she was going to come home.

When she got married, the biggest thing on our list for the wedding day was security. Where is he? What's he going to do when he finds this out? Rumors are rumors. My daughter is best friends with his brother, odd as it may seem. But we knew he was going to find out.

We were very lucky on that day that a dear friend came to us and said, he's back in the hospital. You don't have to worry this day. What a

blessing that was for her that day.

CHAIRMAN MAITLAND: Right.

MS. MECKLEY: Since then, she has gotten a home. We got more and more and more letters that says he is going to find her, he's going to get her.

CHAIRMAN MAITLAND: Right.

MS. MECKLEY: We had a security system put in. Our name is on the alarm. We were coming home from Harrisburg one day. We got a phone call from the alarm system, from the security system, that said the alarm is going off and your daughter is home. We couldn't reach her. We didn't know what would happen. The estimated time of arrival for the police to our house is 12 minutes.

CHAIRMAN MAITLAND: I see.

MS. MECKLEY: What do you think can happen in 12 minutes? Are we afraid? We are constantly afraid. Do we ever want her to be alone? No, but she's a grown-up woman. She's got a good job. She's got a good life. If only we could help her with this part of her life. It affects everyone. It literally affects everyone.

We have people calling us all the time. Did you see that black car on so and so's

road? That could be it. You better check it out. Our local police are wonderful. They check things out for us all the time, even though there's nothing they can do. They want to help us. This is how we live.

CHAIRMAN MAITLAND: Over the past 14 years, have you noticed a predictable pattern of hospitalizations, perhaps while he is treated you don't hear from him and then the deterioration begins?

MS. MECKLEY: Yes, absolutely. When he is in the hospital he is not allowed to write, so his mail is censored. When he is in the hospital, we don't receive any mail.

Again, when they let him go home for holidays, that's when we start to see the mail again. This man has certain holidays and dates in his mind. If you read the last letter -- before the very last letter, he's talking about a seven-year time period and then another seven years. I suffered seven years, don't make me suffer seven more.

He always puts things -- he always paraphrases things and always puts things like into a category whereas Valentine's Day, Christmas, his

birthday now is coming up which is a huge deal. He has invited her to meet him. He's even telling her what he wants her to wear, to bring $100,000 in cashier's checks and $100,000 in bills, hundreds, twenties and fives. This is the kind of thing that we go back to all the time.

I have noticed patterns. I do think that when he was in the halfway houses and was receiving his treatment in the halfway houses, because apparently they can't go out unless they take their meds, we would go six months without a letter, maybe even longer at times. Definitely when he was in the hospital we didn't hear from him. He wasn't allowed.

Yes, I definitely notice a difference.

CHAIRMAN MAITLAND: It might not be fair to ask you, but do you know if he has ever been incarcerated because of his conduct related to his illness?

MS. MECKLEY: I know that he was in juvenile hall when he was very young, but I do not know of any other incarceration or any kind of -- he states in his letters all the time that he's in huge trouble. What that means, I don't know.

CHAIRMAN MAITLAND: And do you believe

if House Bill 2374 were law today that you would be willing to petition for his involuntary commitment, and if the judge looked at the totality of the circumstances and ordered forced treatment even on an outpatient basis, that your situation would be greatly improved?

MS. MECKLEY: I do indeed.

CHAIRMAN MAITLAND: Thank you very much.

MS. MECKLEY: I really do. Thank you.

CHAIRMAN MAITLAND: Mr. Schwoyer.

MR. SCHWOYER: I just wanted to comment. I read your prepared remarks. One of the things that struck me was your comments about whenever you tried to find out information about him and his illness and the status, speaking hypothetically, it's confidential and you're not allowed to know.

MS. MECKLEY: Right.

MR. SCHWOYER: And you're not allowed to know what kind of a vehicle he drives, the make and model that he might drive. Yet he somehow seems to find out when your daughter is getting married and where you live.

MS. MECKLEY: Exactly. The only

reason that I know that he had previously been in a black car is he came to my house. I dealt with him face-to-face. It wasn't nice. It wasn't nice.

MR. SCHWOYER: Thank you.

MS. MECKLEY: You're welcome.

CHAIRMAN MAITLAND: Ms. Mendlow.

MS. MENDLOW: Ms. Meckley, can you tell us if anyone in the mental health system -- and this would be in which county?

MS. MECKLEY: Adams County.

MS. MENDLOW: Adams County. If anyone has any additional insights as far as psychiatric treatment for this young man. It seems that he certainly has had treatment and sometimes it's been successful. I was just wondering if anyone has really done the homework to look at why things have broken down and why he has not been consistent and if anyone, an expert, has been called in to take a second look at this, his entire case, because of these threats to your daughter and your family.

MS. MECKLEY: If there is a suggestion on how I would go about doing that, I would certainly be willing to do that. I have spoken to his case workers. I have contacted the Mental Health Association in Adams County and in York

County. They tell me that they can give me no information. They can take my information, possibly use it, possibly not use it.

MS. MENDLOW: I guess what I'm wondering is have you not heard anyone say, we have decided based on the seriousness of this case and how it's affecting your family, that we have initiated something and that we are taking a second look at what is going wrong to see if there is something else that we can do further.

I don't know that there's a magic bullet, but I was just wondering if anybody has expressed the initiative to at least do some more detail work on this, because perhaps there is some additional intervention to help provide more consistency in taking his medication.

MS. MECKLEY: Each time I speak to someone at the Mental Health Association, it's pretty much the same conversation over and over again.

MS. MENDLOW: I see.

MS. MECKLEY: It's not that they don't believe me. It's not that I don't have documented proof. They certainly get all my letters, copies of the letters.

MS. MENDLOW: I see.

MS. MECKLEY: But what they are saying is that their hands are tied to commit him. Until he does harm to himself or to someone else, physical harm, they cannot commit him to the hospital.

MS. MENDLOW: Right.

MS. MECKLEY: Now, the previous times that he was committed, it's my understanding he tried to commit suicide or at least intimated that he was going to. Those are the reasons that he was previously in the hospital. But they tell me that this is not -- until he harms someone --

MS. MENDLOW: You were probably here when Dr. Fisher testified.

MS. MECKLEY: I was.

MS. MENDLOW: The importance of trust and that that was a key aspect. For that reason, I guess I would very much be interested in seeing if anyone could take a second look and see if he has built up some kind of trust with a psychiatrist or mental health professional.

And as far as the issue of release of information, confidential information, I'm not sure that that is going to be the result of this legislation, but I still am interested in seeing if

that part of the system could work to look at where trust had broken down, where treatment had broken down, what can be done.

MS. MECKLEY: Absolutely.

CHAIRMAN MAITLAND: Thank you very much for your testimony, Mrs. Meckley.

MS. MECKLEY: Thank you.

CHAIRMAN MAITLAND: I would like to welcome our colleague Don Walko from downtown Pittsburgh.

Don, thanks for joining us.

REPRESENTATIVE WALKO: Thank you.

CHAIRMAN MAITLAND: Next we have Mr. John Voron. Good morning.

MR. VORON: Good morning. I am John Voron. I'm a consumer of mental health services. I thank you for this opportunity to give testimony on House Bill 2374. I think this legislation has the potential to have a direct impact upon myself.

I would like to start out by sharing some background information on myself. I first started having symptoms in 1981 when I was 21 years old. Some of these symptoms were racing thoughts. I was delusional. I experienced -- I thought that I had special powers connected to God.

These symptoms became so severe that I voluntarily sought out medical attention. I was placed in a voluntary psychiatric facility. I was put on heavy doses of psychotropic medications, Mellaril and Haldol, to control symptoms. Within six months, however, I could no longer tolerate the side effects so I quit taking the medication. And as other consumers like myself had a severe return of symptoms, I was involuntary committed to Torrance State Hospital. I was given different medications at this time and continued on Haldol, but added Thorazine and Lithium.

At this time, my wife left me. She was told by the doctors after the first week of my hospitalization that I would probably not be released for up to a year's time and I would not be normal again. I was fortunate this time not to lose my job on the railroad, but the stigma that I had felt as a result of being in a state hospital was unbearable. The side effects that I had were heavy twitches and involuntary movements from the medications.

When I voiced my concerns about these symptoms to the doctor, the doctor said to me, it's better than being in the hospital, isn't it? So

what I did this time was I adjusted my medication myself on my own. I took just Lithium with small doses of Haldol. Although you may think this was wrong, I felt I had no medical support. Fortunately, for three years this did work, my adjustments in medication. And I remember this as being like the best three years of my life.

But, unfortunately, in 1986, I had another psychotic episode which landed me in Torrance Hospital again for three months. At this time, I was placed on an outpatient commitment for up to four years. I had no choice at this time but to take my prescribed medications which had a toll on my physical well-being at this time.

I cycled in and out of the hospital many times, and I even had bouts of violence due to my psychosis. I'm telling you all this because I feel that I'm exactly the type of person that you are talking about when you propose changes to the Mental Health Procedures Act.

However, I would like to tell you what made a difference in my life, things that I think can improve the Mental Health System and help other people like myself.

The thing that made a biggest

difference in my life in coming to understand that I need to be on medications has been the peer recovery movement. When I moved to Greensburg, PA, in 1993, shortly after I got married, I met a group of people who were dually diagnosed.

I found the support I needed and I was able to come to terms with my side effects. I helped to educate myself and understand that support groups helped to support other people. I also became a member of the Pennsylvania Mental Health Consumers' Association, and I felt empowered because I felt that I wasn't alone, that there were thousands like me.

Having choice. For so many years, I didn't know -- because I was on the access card -- that I could find another psychiatrist to have someone treat me. That was an important part of my treatment, that someone could understand me that I could talk to, that I could trust, that I wasn't stuck with a specific psychiatrist. My peer support group helped me learn differently. Finding the right doctor was one of the biggest steps in my recovery. I considered this important in my overall recovery. I also wasn't made aware for so many years that there were good programs that I could

access, and that there was peer support, and a focus on recovery.

Finding good aftercare treatment options. After years of not having effective follow-up services, I became involved with some great aftercare treatment. Some of these were a mobile psychiatric nurse, a great case manager, and my bipolar support group.

Being able to use my experience and skills to help others is also a great thing. For the past couple of years I have been employed in the mental health field. I first started out as a consumer satisfaction team member where my job was to go around and serve consumers and give them a voice and find out where the services were.

I was a mobile drug and alcohol counselor and was able to stay sober and help others who were going through the same struggles. Now I'm an empowerment specialist where I travel throughout western Pennsylvania educating consumers on the possibilities of recovery, and giving them the empowerment through the recovery process.

I found that through years of being in recovery, recovery isn't just about medication alone. I know now, through having a good

psychiatrist, from learning from other consumers that I must practice self-care. This is empowerment. I must report changes immediately to my doctor, learn to relax and be good to myself by getting proper nutrition, sleep, exercise; and I must attend my support groups and reach out and help others which, in turn, helps my recovery.

The commitment process that currently is in place has helped when it has needed to. However, when I was in the commitment process back in the '80s, it was so stressful because I didn't have the right doctors in place at the time. If I had to experience constant forced treatment, I feel as I would have tried to stay away from mental health treatment at all costs.

Mental health consumers need to be assured that good treatment and rehabilitation programs are available to them, and that they have good doctors and workers that they have voluntary access to these needed services. In too many communities, there are not good systems of treatment, rehabilitation and support available for them. People in our state can't get the good programs.

However, there are good laws that

mental health workers can get to them such as mobile therapy and mobile rehabilitation. These services are not available the way they should be. They also need to be aware of peer support, of the possibility of recovery.

The way this legislation is perceived is that there is no hope of recovery, that once diagnosed, we will always be so sick that we will never be able to make judgments or decisions for ourselves. This is a mistake that will strip us of hope, which studies have found is the most important part of the recovery process.

We shouldn't have to get so sick that we get beyond the point of recognizing ourselves that we need more structured help. Years ago, I used to be able to go to the ER before I became a threat to myself or someone else, and just get help for a couple days and avoid a long-term hospitalization or commitment. I guess now because of managed care, I can't do that. I feel that that is a disservice to myself and the system.

Psychiatric advance directives are something that can be very helpful to address the concerns that this panel has. I know that I can go to my doctor and have a document prepared, and I can

know the things that when the red flags come up in my illness I can avoid a hospitalization or commitment process and not have the doctor start from square one.

Finally, pass true mental health parity. I've been able to graduate from college and sustain full-time employment long after the doctors told me I wouldn't be able to do these things. To be able to continue to be a functioning, tax-paying, voting member of society, I need to have ongoing treatment for my illness. It's hard for me to understand how this legislation recognizes mental illness as an illness, yet it is not recognized as an illness when it comes to private insurance coverage. I know that we are not talking about mental health parity here, but I had to put that plug in.

I hope my testimony has helped you to understand that even those who are considered hopelessly ill and beyond the ability to ever make judgments and decisions for ourselves and experience recovery, are truly able to manage our illnesses and live constructive lives where we contribute positively to our communities. We need to ensure that there is effective voluntary treatment to be

accessed by those in need. Mental health consumers shouldn't have to go through the commitment process to be well.

One thing I wanted to add was when the doctor was talking this morning -- when you're in a hospital, the commitment process -- you're so under -- when you're under a commitment, you are not there for recovery. You just want to get out. You are so focused on just getting out. You are not there for recovery. The times that I've been in the hospital for a voluntary procedure, I was there for recovery, able to work with the doctor, talk about my medications.

However, when I was in there under commitment, I was so focused just talking to my attorney, wanting to get out. I was focused on getting out. I want there about recovery.

Are there any questions?

CHAIRMAN MAITLAND: Thank you very much for your testimony, Mr. Voron.

Any questions? Representative Stevenson.

REPRESENTATIVE STEVENSON: It's great to see the system works in terms of your recovery. Unfortunately, there's a lot of different facettes

to mental illness, quite frankly. This has been very educational for me today. It's not an easy issue at all. I've had very little contact over the years, in the six years I've been a state representative, other than people from my district that have loved ones suffering from mental illness who basically talk to me about the mental health parity issue, and I've signed on to the bill because of that, trying to fight for that.

MR. VORON: Great. I'm glad to hear that.

REPRESENTATIVE STEVENSON: We still have instances that we have to solve. And you were here. You heard Susan Meckley's testimony.

MR. VORON: I did. That's sad. It's very sad.

REPRESENTATIVE STEVENSON: The system has let her down and let her daughter down. We have to try to balance the needs, the government's need to protect people. It's a health, safety and welfare issue versus, I think, to a certain extent, the person's right to self-determination. But more importantly what I'm hearing is the proper method of treatment.

I hear from you -- and you have been

through it -- and I think your testimony made a bigger impact on me than the doctor's. You made a statement that had you been forced to do this stuff, it wouldn't have had the same impact. You just decided that this is the way you had to go for recovery and you did it. I give you a heck of a lot of credit for that.

MR. VORON: Thank you.

REPRESENTATIVE STEVENSON: We still -- I go back to the issue, we still have loopholes in the law that we have to try to close to help people like Ms. Meckley's daughter.

MR. VORON: Right.

REPRESENTATIVE STEVENSON: And we have to work together. We need your help. We need the doctors' help, too, as Representative Maitland said to improve the bill. Something has to come out of this to protect society from individuals that, for whatever reason, can't see that they need help.

MR. VORON: I think one of the things that bothers me about the bill is the fact that when you see a psychiatrist once every four to six weeks for ten minutes, he has the power to say you might do something in the future. We need to commit you. That bothers me a little bit.

REPRESENTATIVE STEVENSON: Well, thank you. I really don't have anything else.

CHAIRMAN MAITLAND: Don?

REPRESENTATIVE WALKO: No.

CHAIRMAN MAITLAND: Mike?

MR. SCHWOYER: Thank you for coming today.

MR. VORON: Sure.

MR. SCHWOYER: You are not the first person that talked about forced medication and forced treatment. When I read House Bill 2374, what it says to me is that it's adding an additional criteria to form the basis of the court -- someone being able to enter an order about somebody on whether -- I don't see necessarily the strapping down on a table and injecting medication as something that I think I contemplate being done with this bill, if this legislation were law.

What I've always thought, and if you can help me or correct my ill thinking or confirm my belief, is if this were the law, an individual wouldn't have to get to the point where you got where you became a danger to yourself or others prior to the forced hospitalization that got you back on track and helped you to meet other people

and help you to understand your illness better, so that you would better self-monitor and make intelligent decisions about yourself.

MR. VORON: I feel that the current commitment laws achieve that.

MR. SCHWOYER: And there would be -- Okay. I just -- the stories and the examples of the consumers who I have witnessed firsthand, it almost seemed to me almost cruel to make them -- have them wait until they decompensated to the state where they became a danger to themselves or others before we were able to do -- we could have done what we did at that point weeks or perhaps months earlier and just kind of helped them to get back on track.

MR. VORON: Why can't we do it on a voluntary basis where you have somebody be able to go to a hospital before they deteriorate?

MR. SCHWOYER: I think you are right.

CHAIRMAN MAITLAND: Yeah. The law even says voluntary treatment shall be preferable.

MR. VORON: Yeah. I mean, you can't walk into a hospital now and say, look, I'm a little bit depressed right now. And they're going to say, are you suicidal? And you can honestly say, not yet. And they'll say, well you go home until you do

become suicidal. That's what they'll say to you. Honest to God, that's what they'll say to you.

CHAIRMAN MAITLAND: Well --

MR. VORON: Unless you're a threat to yourself or others, you can't get into a hospital nowadays. It's sad.

MR. SCHWOYER: I totally understand what you are saying. I still struggle and look forward to talking to other members of the committee about those individuals who don't recognize or haven't yet figured out how to --

MR. VORON: You mentioned that you thought there were two different types of consumers. I think maybe that was true back when you had the harsher medications. Now that you -- I think you have the A-typical medications, I don't think you see that as much anymore. I see a lot of people and I'm in contact with a lot of consumers in my business, and I don't see as much as you're explaining. I really don't. I mean, maybe 10, 15 years ago it was like that when you had the harsh side effects, but now with the A-typical medications and as the doctor was saying you get these formularies straightened out, I mean, and you can get people on the right medications, I mean, you're

going to see a bigger shift in that.

CHAIRMAN MAITLAND: We had testimony last week from people who said that one of the symptoms of their illness was that when they were medicated, they didn't feel they needed their medicine. So the people decompensate, they're committed, they're medicated, they're well, and then treatment goes out the window. It becomes a repetitive cycle, 5, 10, 15 times. It drives families and the victims like Mrs. Meckley crazy because they see it coming. They know it's going to happen. And there ought to be something in the law for a judge and psychiatrist to take that into account.

MR. VORON: Yeah, but even if you have a commitment law in place, you are going to have to get someone to a facility on a daily basis to get their medications, or get a mobile psych nurse to their house to take their medications.

How are you going to monitor the medications? That's going to be a big job right there by itself. That's going to be a big deal right there to do that. That's going to be an awesome thing to undertake right there. Good luck.

CHAIRMAN MAITLAND: Ms. Mendlow.

MS. MENDLOW: Mr. Voron, thank you very, very much for your testimony. One thing that struck me was how you identify one of the problems in the system, the relationship with the doctors, that you felt that the biggest stumbling block was not having access in your treatment to a doctor who you could share the side effects of your medication, and your frustration then led to your having to try to manage your own meds, etc.

MR. VORON: Right.

MS. MENDLOW: I was just wondering, isn't there in the mental health system anything like some kind of an advocate, like a special parent advocate who can sometimes -- who can sometimes intercede that go through, like, discussions of treatment plans? And the reason why I'm asking is -- even with Ms. Meckley's case, is there some mechanism in the system of some kind of advocate to kind of intercede between family/patient/doctor?

MR. VORON: There are patient advocates out there. For about the first six to eight years I was in the system, I really wasn't afforded the ability to look at supports and services that were out there.

I saw a doctor, a therapist. And I

didn't see a case manager or a nurse or an advocate. I wasn't aware that these things were out there. I kind of, like, fell in. I found these things on my own after being in the system for about eight to ten years. So there are patient advocates out there, yes, there are.

MS. MENDLOW: Is that someone who is a volunteer or someone who actually has an appointed position?

MR. VORON: They are appointed to the Mental Health Association, I know that.

MS. MENDLOW: Thank you.

MR. VORON: Sure.

CHAIRMAN MAITLAND: Thank you very much, Mr. Voron. I appreciate your testimony today.

MR. VORON: Thank you.

CHAIRMAN MAITLAND: Next we have Taylor Andrews, Esquire, the Chief Public Defender of Cumberland County.

MR. ANDREWS: Thank you very much for the opportunity to be here. I do want to vie for the competition of who came the farthest. Just 24 hours ago, I was in Mexico City. I didn't come back just for that purpose, but I think I'm in the running, at least in the competition.

I apologize, I do not have a summary of my written remarks, but I do have my remarks in writing, and according to the instructions I was not to just go through that. So I'm going to leave my written statement to speak for itself.

As I have been listening to other people testify, I have just been making some notes of things that I might want to emphasize in my comments. I'm disappointed that I wasn't here early enough to hear all of Dr. Fisher, because I would have liked to have heard all of his testimony, but it was a bit of an adventure getting here this morning.

What attracted me to this issue -- well, a number of things attracted me to the issue, very personal matters, just as my good friend and respected co-board member, Mr. Jevon, back here who I have a lot of esteem for. I'm active with NAMI, and usually what brings you to NAMI is an experience with somebody in the family.

Also, as chief public defender in Cumberland County -- and I've been chief public defender since 1976 -- from that vantage point, I have witnessed the criminalization effect of our current public policies reflected in any number of

ways, whether it be restricted formularies, whether it be funding shortfalls. One of the ways, in my opinion, is the restricted nature of the commitment standard in the Mental Health Procedures Act.

I've seen what this does. People talk about liberties and I am a member, but I'm not here speaking for them. I see a lot of my clients in criminal court who are mental health consumers, though they may not be in treatment, their liberty is there in the county jail. And they're in the county jail for months, and we're not talking just one or two. It's become a trend. And it's a recognized trend. It's been recognized by the Department of Justice.

I heard a comment as I was coming in, I think it was some of the questions and answers of the good doctor, about mental health courts. And that's a reflection of how to deal with the criminalization process.

I think it's a terrible, terrible thing that is going on now where individuals who are not effectively responded to by our mental health system are now going to be responded to by our criminal justice system. We are creating protocols and procedures for that to occur.

My understanding from the first mental health court judge that existed down in Broward County, Judge Wren -- and I heard her speech within about a year or two after she had started that court -- was that, yes, some diversion might occur. That's really not the objective of that court. The objective of that court is treatment. The objective of that court -- it's clear what happens is since there is no coercive power to Florida's counterpart to our Mental Health Procedures Act, what they call their Baker Act, the coercion comes out of the criminal courts.

You get the individual into criminal court and it will become a condition of -- whether it's a condition of their ARD, which they will eventually earn a dismissal of the charges, or it will be a condition of their probation if they never have to go to jail or to get out of jail on bail before they are sentenced, or it might be a condition of their parole after they serve a portion of the time. But it's the power of the criminal court that is going to be the coercion that people are so concerned about. Now, I think that that's unfortunate and regrettable, and we should look for ways to alter our public policy so there is less of

a need to deal with mentally ill individuals in our criminal courts who are essentially there because they are mentally ill.

One of the things that I think has been recently recognized -- and, chairman, you commented on this in your question to Mr. Voron -- is the phenomenon which Xavier Amadore calls anosognosia. It is -- I'll give you the spelling afterwards. He wrote this book, I'm not sick, I don't need help, where he was a research psychologist, a Ph.D., at Columbia University and has demonstrated that a high percentage of individuals with very serious mental illnesses that have psychosis as a feature have significant impairment of their own illness, of their own awareness of their own illness. It's not a matter of pride. It's not a matter of just coping. It is part of the illness. I don't think it's part of the medication for the illness. It's part of the illness.

That's what keeps a lot of people from treatment. They are not individuals I suggest to you who the Mental Health Consumer speaks for, because these are individuals who would never identify themselves as mental health consumers.

These are individuals that I'm representing in the county jail, one of them right now for criminal trespass at his mom and dad's house because they're crazy and I'm crazy and everybody else is crazy. And he doesn't need any medication.

What's his crime? He's at his mom and dad's house. What institution is dealing with him? Our county jail. He was not -- you cannot have a successful intervention under our civil law for this individual as our civil law is currently written.

There was a comment earlier about how this bill could possibly empower individuals to commit other individuals who are just eccentric. I suggest to you it does that no more than our current law. The way in which the proposed bill would adjust the trigger for an involuntary commitment in no way changes the definition of what is mental illness. There still has to be a mental illness. And that's no different under the law as changed by this proposed bill than under the current law. So I think that that's just not accurate.

One other point as to the -- my understanding as to the importance for there to be the ability for an effective intervention in a civil setting, particularly for a first onset of a

psychotic break, is it is my understanding there is research out of a doctor in North Carolina that indicates the longer an individual remains psychotic without a response, without an effort to restore that individual to a nonpsychotic condition, the less complete the restoration is going to be.

There can be permanent damage to an individual who is in a psychotic state for an extended period of time, because they have not yet deteriorated to what we now define as a clear and present danger, possibly because there is no overt act, possibly because they are only damaging property rather than assaulting people, possibly just killing the family pets rather than acting out against their siblings.

It's important that individuals not be -- that there be an effective way to respond with due process, with criteria that are clearly established, so that there can be a response in civil court to individuals when they become psychotic.

I've read comments and I've heard comments here about many things that could make the treatment system better. I agree with most of them, I will tell you. I mean, better formularies, better

supportive treatment, better funding, better peer organizations and influences. I agree with all of that. But it's somewhat off the point of what we're about here, because none of that really affects that population that is absolutely convinced they have no mental illness. You can make services as complete and whole and welcoming as you possibly can, but if an individual thinks that's for you, mom and dad, that's for you, neighbor, that's for you, Mr. Police Officer, it's not going to make any difference.

I would point out that Dr. Fred Frese was one of the founding board members of the Treatment Advocacy Center in Arlington, Virginia, which is an organization I worked for for two years, whose mission it is to bring about reform similar to the very same reform that's referenced in this House bill that Dr. Fred Frese is on the board that is pursuing that.

Here, again, my understanding in Pennsylvania, unlike some other states, this whole question of forced treatment, not a commitment to where treatment might occur or might not occur but forced treatment, that is what involves an individual's right to refuse treatment, a right to say, I'm not taking your gosh darn medication even

if they are forced into an inpatient facility really isn't addressed in our current Mental Health Procedures Act. It's not addressed by this bill either.

There are some other states that actually have an adjudication, and appoint like a guardian to make treatment decisions where there is a formal substituted judgment and empowerment of another individual to make a treatment decision where the consumer loses the ability to say, no, I don't want that treatment.

Our current act does not have it and this doesn't change it. What, as I understand it, takes place in Pennsylvania aside from an emergency situation where there is a very acute illness that would have to be dealt with by emergency treatment, it's negotiated.

Mr. Jevon talked about negotiations with his son over cigarettes. I'll tell you there are parents all over that come to support meetings regularly, whether it be once every two weeks or once a month, to prop each other up to be able to coerce their kids that you can only stay home if you take your medication. That's the only way this is tolerable. If you want to be here, you have to take

medication. That's a form of coercion.

But it's also negotiated in the treatment setting, because there is still a right to refuse. What these proposed amendments do and why I support them is they don't -- they change maybe some of the cards that people are holding in that negotiation. For instance, the very last change in this proposed House bill that adds in the whole array of circumstances that are to be taken into account as to where treatment -- whatever treatment is to be provided, where it is to be provided, that medication compliance is added. That's increasing the negotiating power of the treatment team as they negotiate out what is going to be the form of this treatment with that individual.

The new provision (1.1) that I think is on the top of page 5 of the bill, I agree with Mr. Schwoyer that this does not constitute forced treatment or forced medication. It doesn't say that at all. It does say that if you have a prescribed medication and you stop taking your medication and you start to deteriorate in such a way that it's predictable that you are going to have serious either physical or mental debilitation in the next 30 days, then that constitutes a clear and present

danger to yourself.

John, who just testified, indicated how he was concerned that this bill would have applied to him and made his situation so much worse, because at one time he had adjusted his own medication for the better for three years. This never would have come into play for him. According to his own statement, there was no deterioration until sometime later. At such time that there is a deterioration, there still would have to be -- there is an objective standard there to determine. It doesn't have to get to the point that you are acting out with a threat of physical harm to somebody else or a threat of self-destruction on yourself.

I support the bill. I think it would make valuable adjustments to our current law. It's the sort of adjustments that are being made in other states. Sometimes we lose sight of what is happening in other states in the way of legislation. I believe Mr. Stanley may have given you testimony last week. I'm not certain about that. I know they keep a pretty active scorecard as to exactly what's going on across the country.

This type of reform is occurring more and more across the country, I think, upwards of

approximately a dozen states or so. They reformed their commitment standard to include a basis other than just the police power rationale.

I see this, the changes in this bill, not so much to address the situation that Ms. Meckley has given that testimony about -- she is in a very, very difficult situation -- but I see it as beneficial to the consumer. I see it as beneficial to the loved ones of those of us that are in NAMI.

I want to make clear, just as Mr. Jevon, I'm here in my own individual capacity speaking. I, basically, think these changes would be available.

I'll stop there and answer any questions.

CHAIRMAN MAITLAND: Thank you.

MR. ANDREWS: You're welcome.

CHAIRMAN MAITLAND: Any questions, Don?

REPRESENTATIVE WALKO: No.

CHAIRMAN MAITLAND: Tom?

REPRESENTATIVE STEVENSON: No.

CHAIRMAN MAITLAND: I will ask a couple while they think about it.

We heard from Dr. Fisher this morning

that there was a possibility or stances that he has witnessed where family members have exploited the system, the commitment system, for various reasons. Do you think it would be beneficial to put into the language of the act that the judge should look, consider, whether or not there is an exploitative reason for the proceeding, to make that a box to check off in the judge's deliberation?

MR. ANDREWS: I guess I would see no harm in doing that. I would expect that to be done as a matter of course in Pennsylvania. I don't know that all states are this way. An individual in a commitment process is represented by counsel. It's provided out either on a contract basis or the public defender's office. Certainly, it would be the job of the legal representative of the subject of a legal proceeding to make exactly that kind of an argument.

I will say at least in the NAMI community locally, those aren't the concerns that we hear. The concerns aren't that there's an excessive amount of attempts to use the Mental Health Procedures Act, it's just that it's too darn hard to use effectively at all.

Our local mental health director in

our two counties, Cumberland and Perry Counties, recently gave a report that just in our area in the last three years we've lost 60 inpatient beds. There really aren't resources, many resources, there to be committed to for ulterior motives.

CHAIRMAN MAITLAND: You've seen a lot of commitments, I would imagine, over the course of your practice as a public defender.

MR. ANDREWS: Yes.

CHAIRMAN MAITLAND: What's your sense of the success of the commitment process in more or less stabilizing the patient for a lengthy period of time? I mean, once someone has been committed, do you see them again and again or again or do the majority of them --

MR. ANDREWS: It's really -- I couldn't give you a number. There are some wonderful cases out there where I saw -- I remember one individual's first onset of a psychotic break and he was found naked in another person's house, having busted it up, causing about $30,000 worth of damage. He had cut himself as he broke the porcelain toilet. He had bled all over their house. I mean, the damage was eventually like $30,000.

The police that responded, to their

credit responded, they certainly didn't forget the prosecution. They took him to the local mental health center and he was admitted to the local mental health center for a short time and then sent to the state hospital where he was for about six months.

I had an opportunity -- I'm an admissions officer for a NAMI chapter. Because of wearing that hat and the public defender hat, I'm able to reach out to the family and say, you don't understand what's going on here.

There's a young fellow who responded to treatment with new medication at the state hospital, came out and I've heard of no problems since. He is not compliant with the treatment and is doing very, very well.

That's one example. We certainly have other examples of individuals who we see regularly over and over and over again. I can't give you any standard on that. It is a very individual listing, a very individual listing.

CHAIRMAN MAITLAND: There were comments from Dr. Fisher, and Mr. Jevon commented that cruelty to animals is normally not a symptom of serious mental illness. What is your perspective on

leaving that in or taking it out?

MR. ANDREWS: Well, you have to be careful not to misread this bill. This doesn't say if you are cruel to animals you are mentally ill. You first have to be found to be severely mentally disabled. And for that, there has to be a mental illness found.

Then we're talking about what would constitute clear and present danger. And killing animals, not flushing duckies down the toilet but that you are stringing up the house cats, for somebody that's seriously mentally ill I think that warrants to maybe have an examination.

Just anecdotally -- and I know it's not a scientific study -- Russell West, the individual that went into the Capitol, he killed the family pets. It was like a dozen cats that he killed. And they couldn't respond with a civil commitment out in -- I forget whether he was from Montana or one of the Dakotas.

If somebody is acting in such an agitated state and they also have a mental illness, I suggest when it's appropriate to look at it more closely and look at it in more detail. The fact that it's not a person that they might be acting out

at but property -- I mean, if somebody takes their sledge hammer out and is bashing up their neighbor's car, the fact that their neighbor is not in the car currently, well, that's not a clear and present danger to another person. That's a criminal mischief is what that is. So where you go, sir, is you go to jail.

CHAIRMAN MAITLAND: I wanted to support your point on the criminalization of the mentally ill, the Treatment Advocacy Center. Some of the statistics they gave last week showed that serious mental illness occurs in about 1 percent of the population at large but about 16 to 20 percent in state and county inmates, for example.

MR. ANDREWS: That may be a little much of an overstatement in my opinion. I mean, schizophrenia is 1 percent; bipolar disorder is somewhere between 1 and 2 percent. So if you put the two together, you're probably around 2.5 or 3 percent.

The statistics from the Department of Justice said 16 percent wasn't limited to just schizophrenia and bipolar. So you end up with a little bit of a comparison of apples and oranges.

I think when we're talking about the

commitment law, we really are talking about the law that is going to be applied to an individual who is significantly mentally ill. We're not talking about mild depression. We're talking about somebody that really is most frequently in a psychotic state and can't be reasoned with into a voluntary treatment.

CHAIRMAN MAITLAND: Lastly, for me anyway, do you get calls from the family members that say, you know, my son, my daughter is off their medication, they are starting to act out, what can I do.

MR. ANDREWS: Absolutely.

CHAIRMAN MAITLAND: What is your experience with that in our current law?

MR. ANDREWS: Well, for several years we recently had a police officer who was very sensitive. And that was our best resource, because that was an agency that would come out and come to a home, and a police officer did have the arrest power to take somebody in for an examination, but invariably even if we could get the police officer to respond, there would be frustration because the commitment standard test would close the door.

We look for any leverage we can to do the negotiation we referred to. I was surprised to

see but happy to see one of the testimonials you have in writing is somebody from my local county and it's somebody's situation I know quite well. And it's just a terrible situation that the current law cannot address.

CHAIRMAN MAITLAND: They have to get to such a point.

One last thing. You worked with many judges on these issues in Cumberland County over the years. How would you characterize the knowledge and the treatment that the judiciary brings to these cases?

MR. ANDREWS: Recognize I still practice before these same judges and I see somebody is taking down my remarks.

CHAIRMAN MAITLAND: Tell me afterwards.

MR. ANDREWS: It varies. I will say that with the NAMI Organization, we did judicial training at the trial judges' conference about four or five years ago with a Dr. Roger Haskett from right here in Pittsburgh. And it was clear to me that the judges had a thirst for the information. Their reaction to the three-hour training that we brought them, that was some very practical

information about individuals with specific serious mental illnesses and how they might manifest themselves and how that might affect decisions that judges would have to make in custody cases or in criminal cases or in other cases. And we got very, very positive evaluations for the need for that kind of thing.

CHAIRMAN MAITLAND: Any other questions?

MR. SCHWOYER: I'm curious. Can you tell the committee what sort of things are out there, are going on out there, in the real world in the area of forensics and mental health? Is it an issue? Are people thinking about it, concerned about it, working on it, talking about it?

MR. ANDREWS: I have been involved in several conferences and planning groups for conferences, and everybody is looking for best programs, model programs, and their model programs. They are working on a mental health court right now in Allegheny County that I think is modeled, if not directly, indirectly after the court that started in Broward County.

There are crisis intervention teams now in more than a dozen cities across the country

that are modeled after the Memphis crisis intervention teams that were started, where a cadre of police officer with specialized training to respond in a sensitive and appropriate fashion to an individual with a mental disturbance for whom the police are called with a single point of entry for an evaluation in the mental health system, so that the police officer can drop them off and go back on the street and somebody else is going to make a determination of what's appropriate.

There was a PACT observation made here how if somebody doesn't want to take their medication, well, how are they going to take their medication, are you going to send a psych nurse to everybody's house?

Well, PACT, that's Program for Assertive Community Treatment, that is a program that originally came out of Madison, Wisconsin. There is a PACT program now getting started in Bucks County, Pennsylvania as a model. I understand there is a program similar to PACT with a different name already in Allegheny County.

So there are many, many different programs trying to address these problems, many of them in the context of the criminal courts, if

that's specifically what you're asking about.

MR. SCHWOYER: Would the changes in House Bill 2374 be consistent with those concepts, or would it hinder what's going on or help, or what do you think?

MR. ANDREWS: In my opinion, it would make it less necessary to have if you have an effective civil intervention court. A significant number of individuals who are now hitting our county jails would not hit the county jails. So you wouldn't have to have the programs built into our criminal justice system to try and extricate people out.

And we also wouldn't double stigmatize people not only with a label of mental illness, but also a criminal conviction or at least a criminal prosecution.

MR. SCHWOYER: In the course of your involvement with this issue, have you in recent times had an opportunity to look at the cost of mental illness to the criminal justice system, whether it be time or whether it be cost of medications?

MR. ANDREWS: I know our county and I think I have been to enough meetings where most

County Prison Boards, one of their budgetary problems is the cost of psychotropic medications.

MR. SCHWOYER: Right.

MR. ANDREWS: My reaction is, well, no, you need to have those medications, maybe even spend a little bit more to get the better medications that the doctor was talking about.

The Ohio Department of Corrections, I think, has learned that there is a benefit to use the A-typicals in the state correction system. I'm not sure that we're there yet in Pennsylvania.

I don't have any specific cost benefit analysis. I know that there are very real costs to the criminalization process, dollar costs, and more than that there's just the cost of human suffering from people being prosecuted.

I've talked to the people here trying to extricate out. I did make reference in my comments. Sometimes you just have terrible situations. Mr. Jevon referenced two folks here in Allegheny County. Sometimes there are just horrendous circumstances. It is infrequent. I do like to dispel the notion that folks with mental illness are significantly more violent. They are not any more violent at all than the general public

if there is treatment compliance.

MR. SCHWOYER: Thank you.

MR. ANDREWS: There is another study on coercion. And I just read notes of it as it was in process. Basically, it was surveying consumers as to just how did they react to the process that had them in treatment. And as I understand the results of that study, it wasn't -- they didn't react to whether the initiating event into treatment was an involuntary commitment or a voluntary commitment. What they reacted to was whether their dignity was respected and whether they were treated with respect.

MR. SCHWOYER: Right.

MR. ANDREWS: And even individuals who were committed involuntarily, if they were treated in a dignified fashion, treated with respect as very important individuals, the sense that the study on coercion, as I understand it, was the feeling afterwards wasn't any more negative. Actually, it was less negative than if they were voluntarily admitted and treated poorly by the people that they encountered.

MR. SCHWOYER: Thank you.

MR. ANDREWS: You're welcome.

CHAIRMAN MAITLAND: Ms. Mendlow.

MS. MENDLOW: Hi, Mr. Andrews.

MR. ANDREWS: Hello.

MS. MENDLOW: We have heard from the Psychiatric Society, and I guess what I was looking for is in your experiences in dealing with psychiatrists in your work, because it seems like the position that the Psychiatric Society is taking at least is one of great fear and apprehension about any kind of expansion to the criteria for involuntary commitment. And yet we hear about the problems in getting any kind of treatment, voluntary or involuntary.

I'm just kind of confused. I'm wondering -- it's been a couple years back -- we were hearing a little different tune. They seemed to be much more concerned from the psychiatric community about the access to the treatment issue in our state. I was just wondering if you have any insights as to what may have occurred, why they are not perhaps, I would say, coming up with more aggressive kinds of assistance for patients?

MR. ANDREWS: I really don't have any insights. I do believe that the point of view of the psychiatric community would be extremely

important. I mean, they are an extremely important player in the whole process of mental health treatment.

MS. MENDLOW: Right.

MR. ANDREWS: As I understood it, the American Psychiatric Association has their own model law, I believe, or principles for a model law that do recognize need for treatment, which this would fall into that category as a legitimate rationale for involuntary treatment. But as to exactly why the Pennsylvania Psychiatric Society or Association would take the position they have, I have to let them speak for themselves.

My sense somewhat from listening to what I did hear from Dr. Fisher was that some of it was almost prejudging the constitutionality of a change, that since this would no longer be based on dangerousness, it is suspect, that it would be unconstitutional, and I think that that's not the case. You can have a rationale other than just based upon the police power. It can be based on the power of the state to look after the welfare of the citizens.

I go there reluctantly myself as somebody that knows that government power is

something that has to be pretty well regulated and controlled.

MS. MENDLOW: Thank you.

MR. ANDREWS: Thank you.

CHAIRMAN MAITLAND: Someone from the audience wants to say something.

MS. PETIBONE: I'm from Pittsburgh.

CHAIRMAN MAITLAND: What's your name?

MS. PETIBONE: I want to make a few comments.

CHAIRMAN MAITLAND: Ma'am, what's your name?

MS. PETIBONE: I'm Mary Ann Petibone. I'm the Executive Director of the Pittsburgh Psychiatric Society. I work with Dr. Fisher and Dr. Haskett. We actually represent 400 psychiatrists here in Pittsburgh.

We met last evening to discuss parts of this bill and some of the testimony that Dr. Fisher would present this morning. And one of the issues that you raised was, why are the psychiatrists actually opposing some of this legislation.

I think the real concern there was the fact that once a person is thrown into the criminal

justice mental health system with a 302, they are actually labeled for life, so to speak. It could affect their future in many different ways from the means of access to health care, job opportunities, graduate schools. There are a huge number of factors that would be taken into account and affect that person's life from the very beginning.

So I think the idea with the psychiatric community is the fact that they don't want to force people into a situation, but rather they want to open the access to mental health care in other ways.

I'm sorry. I have to refer to my notes. Mr. Voron spoke about the fact that you cannot go into an emergency room and seek treatment, that you are turned away. That's a huge problem. A lot of these problems are a series of problems that if there is intervention early on, that it would lead to -- it would resolve an issue that may turn out to be a catastrophic event.

So I think the whole idea with the psychiatric community, at least from what we were discussing last evening and with Dr. Fisher's testimony this morning, is the fact that you don't want to see more of a rein put on a person, but you

want to open that field up and let them decide -- like people go for physicals once a year for physical health, there should be physicals once a year for mental health. That could solve a whole lot of problems. If everybody decided, I'm going to go see a doctor once a year, then maybe that would open up some areas for treatment, etc.

I don't know if I answered your question or not. I just thought I had to say something as I'm sitting here listening to you and I know Dr. Fisher did have to leave. He had somewhere else to go this morning.

CHAIRMAN MAITLAND: Thank you.

MS. PETIBONE: Thank you.

CHAIRMAN MAITLAND: Any other questions or comments?

If anyone in the audience or anyone else in the whole Commonwealth would like to submit some written testimony for the record, we'll keep that open for a couple of weeks to enable you to do that.

You would like to say something, sir?

MR. BARN: Yes.

CHAIRMAN MAITLAND: Come up here and state your name for our stenographer.

MR. BARN: My name is John Barn, B-a-r-n. I work for the Grapevine Center. And one of the problems I see here is that no one seems to believe that a person could ever recover on their own. And if you label somebody as having needed medicine, you are going to create that for all their life with this legislation.

Is that what this is about?

CHAIRMAN MAITLAND: Not at all.

MR. BARN: Okay. All right. But another thing is when you go -- when you go in front of a psychiatrist, let's say, or a mental health board, all right, and they consider your faith, your faith in Christ, all right, and they generally end up counting that against you, you know.

Well, I was thinking, like, you know, okay, like, if Noah were here and he were building a boat, you know, in his backyard, I mean, everybody else in the world would think that he was in error. Who would be the one in error? All right. That's one thing I would like to say.

The other thing was that, like, if you were -- if you were -- man was given the choice to eat off a tree of knowledge or good and evil and God didn't stop him, okay, but that's a free choice he

had. All right. And ever since then, a human being has been given the choice to make a wrong -- the right to make a wrong decision and take the consequences for that. Okay. All right. Okay.

I fear that within the mental health system that we don't have -- I mean, you're not given the right either to make your own wrong decision about what you want to put in anymore or to take the sequences for it because they'll -- it's not guilty by reason of insanity. To me that's -- both of those are insane propositions.

Okay. All right. So then later on in the church, Paul said, don't let anybody judge you for what you do and you don't eat, you know. It's then -- the choices of medication that you put into your body is actually a spiritual -- you know, is an issue that we are not allowed to let anyone judge us for, but within the mental health system they do judge you as, you know, you haven't taken your medicine so that -- so now you are less of a person and what you say doesn't mean anything anymore. It's like, you know, understand what I'm saying?

CHAIRMAN MAITLAND: I sure do.

MR. BARN: Yeah.

CHAIRMAN MAITLAND: If it were an easy

problem, we would have solved it already.

MR. BARN: Well, here's another thing, all right. Some people are in the middle of a spiritual crisis sometimes. And, let's say, if today you learned that you were lost and you were on your way to hell and you didn't know your way out, you might try a whole lot of funny things to try to get to heaven, all right.

CHAIRMAN MAITLAND: Thank you very much.

MR. BARN: And they might not make a whole lot of sense, all right. But it's a thing you have to work out with God, you know. And for somebody like a doctor and a panel of doctors to say that, you know, this is a symptom, we have to get it out of you, when you are trying to resolve a spiritual crisis.

CHAIRMAN MAITLAND: Right.

MR. BARN: I know for a while there I thought I committed the cardinal sin. I had to work that out, you know. And when a -- and that was a terrifying part of my life, all right.

CHAIRMAN MAITLAND: Right.

MR. BARN: When I would -- when you would go -- you know, a doctor couldn't understand

that, you know. And he would think that's -- you're trying to get -- you're trying to -- you know, he's trying to take away from you and correct something a little bit before maybe it's time.

CHAIRMAN MAITLAND: Okay.

MR. BARN: That's kind of what I fear in some sense. And then -- but there's one other thing.

CHAIRMAN MAITLAND: Sure.

MR. BARN: I think -- I know an awful lot of people that -- I work in -- I work at a drop-in center. I meet a lot of people both treated and untreated who in the course of their illness have never committed an act of violence, all right. And so that -- you know, they may have done odd things but they never stalked people, killed people, you know, went to try to rape people, you know, whatever, you know, choked people.

CHAIRMAN MAITLAND: Right.

MR. BARN: And maybe they might have gotten in trouble with the law, you know, in a sense, you know, in the sense of a misdemeanor, you know, but, you know, a misdemeanor. So I think you better take into account -- make a division between those who can -- who can -- who are not guilty of a

criminal act versus those that are guilty of something that is criminal.

And for me, I don't -- I would not -- if I ever committed a crime, whether I was mentally ill or not, I would still want to go to jail because that would be the responsible thing to do as a human being. That's what makes human beings human. We can make -- but do you understand what I'm saying?

CHAIRMAN MAITLAND: I think I do. We don't want to infringe on a person's spiritual journey.

MR. BARN: Uh-huh.

CHAIRMAN MAITLAND: Until they reach the point of being a danger to themself or others.

MR. BARN: No. No.

CHAIRMAN MAITLAND: Once that line is crossed is when we are looking at intervening.

MR. BARN: Okay.

CHAIRMAN MAITLAND: People that are eccentric.

MR. BARN: But as far as danger goes, I think -- as least as far as the Bible, what I believe in is we all have an old sin nature and evil inside that we have to keep bottled up. All right. Okay. It's our responsibility to manage it. All

right. Okay. Okay. And if we can successfully -- if we have proven ourself to successfully manage whatever is inside, let us free. All right. That's what I'm saying.

CHAIRMAN MAITLAND: Thank you very much, Mr. Barn.

MR. BARN: Set us free.

CHAIRMAN MAITLAND: Mr. Jevon, one last comment.

MR. JEVON: Just a response to Mr. Schwoyer's question. I drop my objection to (2)(1.1) with dropping off the last portion. I would drop my opposition.

MR. SCHWOYER: Thank you.

MR. JEVON: Thank you.

CHAIRMAN MAITLAND: I thank everyone for your attendance. I think the turnout here was very good today. I appreciate all the testimony, verbal and in writing. Like I said, for a couple weeks, we will take further testimony in writing if anyone is interested.

With that, we will call this meeting of the House Judiciary Task Force on Forensic Law adjourned.

(The hearing concluded at 12:06 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
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