

**CUMBERLAND COUNTY
PUBLIC DEFENDER**

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SEP 26 2007

September 24, 2007

Michele Hansarick, Executive Director
Senate Public Health and Welfare Committee
Sen. Edwin B. Erickson, Chair
281 Main Capital Building
Harrisburg, PA 17120-3026

Re: SB 226

Dear Ms. Hansarick,

My perspective on SB 226 is shaped by my 32 years as Chief Public Defender in Cumberland County and my experience as a family member of a loved one with a serious mental illness. I have been active with NAMI since 1992, having served as President of my local Cumberland – Perry Counties affiliate for more than 10 years, and also as President of NAMI Pennsylvania in 2000.

I have heard other advocates say that we should never try to change the Mental Health Procedures Act because when a change was previously attempted in the late 90's all it did was generate division and discord. Despite this, I strongly believe that our current commitment law needs revision.

The narrowness of our commitment standard [imminent danger] frustrates too many appropriate attempts to get help for seriously mentally ill individuals who are obviously in need of treatment, but who are not a "clear and present danger" as that is now defined. When the condition of imminent dangerousness is satisfied, the responding government agency is, more often than not, the police with a criminal charge and imprisonment. The increasing popularity of Mental Health Courts is a product of this phenomena, as the Criminal Justice System tries to devise ways to handle cases where the most significant factor is that the defendant suffers from a serious mental illness. Judge Ginger Wren in Broward County, FL, who started the first Mental Health Court, coined the term *Therapeutic Jurisprudence* for the attitude at work in her Court.

My experience as a family member and NAMI leader sensitized me to these cases and the criminalization process that is at work for many individuals with serious mental illness. Police and family members, acting as problem-solvers, turn to the criminal justice system to access the coercion that is available there to bring an oppositional, though obviously ill, individual to treatment. I have learned through experts and experience that this opposition is often due to significantly impaired insight that is as much a symptom of the illness as delusions, hallucinations, and disorganized thinking.

We need to do something to enhance our ability to reach individuals with a serious mental illness before it is too late; before danger has become actual harm; and before criminal charges are filed.

SB 226 is modeled after Kendra's Law in NY and provides for a commitment to outpatient treatment for a subset of seriously mentally ill individuals who have experienced multiple hospitalizations and/or imprisonments due to noncompliance with recommended treatment. Before Kendra's Law, NY didn't have any outpatient commitment process. SB 226, like Kendra's Law, commits the system to the consumer as well as the consumer to the treatment system. The 19 page Bill places treatment responsibility and provides for oversight to that treatment. This is very much unlike the current system for commitment in PA, whether inpatient or outpatient.

Kendra's Law in New York has produced positive outcomes. It has reached individuals who would otherwise not have been reached. Re-hospitalizations, incarcerations, and homelessness have been reduced without criminalizing the consumer. Because SB 226 is modeled after Kendra's Law, I support SB 226, but with the following modifications:

- In its current form SB 226 does not provide a free attorney to a person subjected to a petition for Assisted Outpatient Treatment [AOT]. I believe that free counsel should be provided as is now the case under the Mental Health Procedures Act.
- The time period referenced in the second prong of the new criteria for Assisted Outpatient Treatment in §305-A, (b)(4)(ii) should be shortened substantially. As currently drafted a person with a mental illness could be subject to AOT as a result of acts of serious violent behavior or a threat or attempt at serious physical harm anytime in the previous 4 years. In my opinion this is too long of a look-back period. I suggest this be shortened to 6 months. The long look-back period sets up proof problems, and may refer to behaviors that may not be relevant in the present time.
- I believe the rigorous and robust AOT provided by SB 226 should be reserved for the most refractory cases. I believe this has been the experience in NY where only 39 individuals per year per 1 million of population have been subjected to AOT.
- The commitment criteria at § 301 of the Mental Health Procedures Act should be amended as was proposed in last Session's HB 433. This would enable successful civil interventions for many individuals who are in need of treatment but are not in need of the intense oversight of the AOT program. I enclose a copy of last year's HB 433 that was drafted with the assistance of a criminal defense attorney and a District Attorney.

In 2005 OMHSAS submitted comments opposing SB 213 [same as current SB 226] that stated:

SB 213 and previous attempts at similar legislation are rooted in the unfounded perceptions that all persons with mental illness are likely to become dangerous if/when their mental health deteriorates and that persons with mental illness are incapable of making appropriate mental health treatment decisions.

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September 25, 2007
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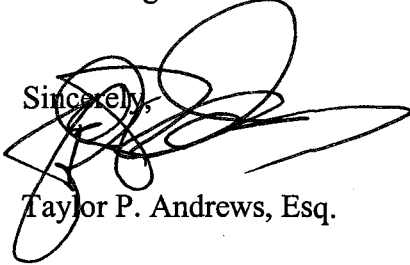
I want to be very clear that I do not subscribe to such beliefs. I believe in the emerging recovery focused treatment system. I am Chair of the Community Advisory Committee of our local community mental health center [The Stevens Center] and we are about to formally celebrate the extent to which recovery has become central to treatment.

I know, however, that there is a segment of the consumer population that cannot get on board the recovery train because of impaired insight and opposition to treatment. I have seen many instances where this has been turned around with appropriate treatment that may have been resisted at the outset, but that was subsequently accepted. In my view SB 226 is not inconsistent with the emerging recovery focused treatment system, but rather a way that the system may reach individuals who otherwise would be relegated to our jails, prisons and shelters.

I commend the Senators who have sponsored SB 226 for putting this Bill forward, and I thank Sen. Erickson and his committee for conducting this hearing to receive input regarding the Bill. I hold out hope that legislation will facilitate earlier and more effective civil interventions and will also halt the process of criminalization of individuals with mental illness.

Thank you for considering these comments and sharing them with the members of the committee.

Sincerely,



Taylor P. Andrews, Esq.

TPA
Encl.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 433 Session of
2005

INTRODUCED BY MAITLAND, O'NEILL, NAILOR, BELFANTI, CRAHALLA,
DeLUCA, DENLINGER, D. EVANS, FLEAGLE, GEIST, GINGRICH,
HENNESSEY, M. KELLER, S. MILLER, MUNDY, NICKOL, ROSS, SAYLOR,
SCHRODER, STERN, E. Z. TAYLOR, THOMAS, TIGUE, WALKO AND
YOUNGBLOOD, FEBRUARY 14, 2005

REFERRED TO COMMITTEE ON HEALTH AND HUMAN SERVICES,
FEBRUARY 14, 2005

AN ACT

1 Amending the act of July 9, 1976 (P.L.817, No.143); entitled "An
2 act relating to mental health procedures; providing for the
3 treatment and rights of mentally disabled persons, for
4 voluntary and involuntary examination and treatment and for
5 determinations affecting those charged with crime or under
6 sentence," further providing for statement of policy, for
7 provision for treatment and for persons who may be subject to
8 involuntary emergency examination and treatment.

9 The General Assembly of the Commonwealth of Pennsylvania

10 hereby enacts as follows:

11 Section 1. Section 102 of the act of July 9, 1976 (P.L.817,
12 No.143), known as the Mental Health Procedures Act, amended
13 November 26, 1978 (P.L.1362, No.324), is amended to read:

14 Section 102. Statement of Policy.--It is the policy of the
15 Commonwealth of Pennsylvania to seek to assure the availability
16 of adequate treatment to persons who are mentally ill, and it is
17 the purpose of this act to establish procedures whereby this
18 policy can be effected. The provisions of this act shall be
19 interpreted in conformity with the principles of due process to

1 make voluntary and involuntary treatment available where the
2 [need is great and its] absence of treatment could result in
3 serious harm to the mentally ill person or to others. Treatment
4 on a voluntary basis shall be preferred to involuntary
5 treatment; and in every case, the least restrictions consistent
6 with adequate treatment shall be employed. Persons who are
7 mentally retarded, senile, alcoholic, or drug dependent shall
8 receive mental health treatment only if they are also diagnosed
9 as mentally ill, but these conditions of themselves shall not be
10 deemed to constitute mental illness: Provided, however, That
11 nothing in this act shall prohibit underutilized State
12 facilities for the mentally ill to be made available for the
13 treatment of alcohol abuse or drug addiction pursuant to the act
14 of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania
15 Drug and Alcohol Abuse Control Act." Chronically disabled
16 persons 70 years of age or older who have been continuously
17 hospitalized in a State operated facility for at least ten years
18 shall not be subject to the procedures of this act. Such a
19 person's inability to give a rational, informed consent shall
20 not prohibit the department from continuing to provide all
21 necessary treatment to such a person. However, if such a person
22 protests treatment or residence at a State operated facility he
23 shall be subject to the provisions of Article III.

24 Section 2. Section 104 of the act is amended to read:

25 Section 104. Provision for Treatment.--Adequate treatment
26 means a course of treatment designed and administered to
27 alleviate a person's pain and distress, to protect a person from
28 predictable deterioration and to maximize the probability of his
29 recovery from mental illness. It shall be provided to all
30 persons in treatment who are subject to this act. It may include

1 inpatient treatment, partial hospitalization, or outpatient
2 treatment. Adequate inpatient treatment shall include such
3 accommodations, diet, heat, light, sanitary facilities,
4 clothing, recreation, education and medical care as are
5 necessary to maintain decent, safe and healthful living
6 conditions. Treatment shall include diagnosis, evaluation,
7 therapy, or rehabilitation needed to alleviate pain and distress
8 [and], to facilitate the recovery of a person from mental
9 illness and to protect a person from predictable deterioration
10 and shall also include care and other services that supplement
11 treatment and aid or promote such recovery.

12 Section 3. Section 301(b) of the act, amended November 26,
13 1978 (P.L.1362, No.324), is amended to read:

14 Section 301. Persons Who May be Subject to Involuntary
15 Emergency Examination and Treatment.--* * *

16 (b) Determination of Clear and Present Danger.--(1) Clear
17 and present danger to others shall be shown by establishing that
18 within the past 30 days the person has inflicted or attempted to
19 inflict serious [bodily] harm [on] to another and that there is
20 a reasonable probability that such conduct will be repeated. If,
21 however, the person has been found incompetent to be tried or
22 has been acquitted by reason of lack of criminal responsibility
23 on charges arising from conduct involving infliction of or
24 attempt to inflict substantial [bodily] harm [on] to another,
25 such 30-day limitation shall not apply so long as an application
26 for examination and treatment is filed within 30 days after the
27 date of such determination or verdict. In such case, a clear and
28 present danger to others may be shown by establishing that the
29 conduct charged in the criminal proceeding did occur, and that
30 there is a reasonable probability that such conduct will be

1 repeated. For the purpose of this section, a clear and present
2 danger of harm to others may be demonstrated by proof that the
3 person has made one or more threats of harm and [has committed
4 acts in furtherance of the threat to commit harm.] the totality
5 of circumstances supports a finding of danger.

6 (2) Clear and present danger to himself shall be shown by
7 establishing that within the past 30 days:

8 (i) the person has acted in such manner as to evidence that
9 he would be unable, without care, supervision and the continued
10 assistance of others, to satisfy his need for nourishment,
11 personal or medical care, shelter, or self-protection and
12 safety, and that there is a reasonable probability that death,
13 serious bodily injury or serious [physical] debilitation would
14 ensue within 30 days unless adequate treatment were afforded
15 under this act; or

16 (ii) the person has attempted suicide and that there is the
17 reasonable probability of suicide unless adequate treatment is
18 afforded under this act. For the purposes of this subsection, a
19 clear and present danger may be demonstrated by the proof that
20 the person has made threats to commit suicide and [has committed
21 acts which are in furtherance of the threat to commit suicide]
22 the totality of the circumstances support a conclusion that
23 there is a risk of a suicide attempt; or

24 (iii) the person has substantially mutilated himself or
25 attempted to mutilate himself substantially and that there is
26 the reasonable probability of mutilation unless adequate
27 treatment is afforded under this act. For the purposes of this
28 subsection, a clear and present danger shall be established by
29 proof that the person has made one or more threats to commit
30 mutilation and [has committed acts which are in furtherance of

1 the threat to commit mutilation.] the totality of the
2 circumstances supports a conclusion that there is a risk of an
3 attempt of self-mutilation; or

4 (iv) the person has acted in such a way as to evidence that
5 he does not have the capacity to make a rational treatment
6 decision, and serious debilitation would ensue within 30 days
7 from a diagnosed condition unless treatment were afforded under
8 this act.

9 (3) A person's history of treatment and diagnosis, and a
10 person's past behavior may be considered in determining whether
11 a person's recent behavior constitutes a clear and present
12 danger to others or to himself.

13 Section 4. This act shall take effect in 60 days.