

TESTIMONY OF

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ON BEHALF OF THE
PENNSYLVANIA PSYCHIATRIC SOCIETY

BEFORE THE
SENATE PUBLIC HEALTH AND WELFARE
COMMITTEE

REGARDING SENATE BILL 226
(MENTAL HEALTH PROCEDURES ACT:
ASSISTED COMMUNITY TREATMENT)

OCTOBER 2, 2007

Good morning, Chairman Erickson and esteemed members of the Senate Public Health and Welfare Committee. My name is Kenneth Certa, MD, a physician specializing in the field of psychiatry from Philadelphia. I have been a physician for twenty-eight years. I currently serve as the psychiatry residency director, and the director of acute psychiatric services at Thomas Jefferson University Hospital, as well as an associate professor at Jefferson Medical College. Most of my time is spent treating patients, and teaching residents and medical students the diagnosis and treatment of mental illness.

I am testifying on behalf of the Pennsylvania Psychiatric Society. I chair our Government Relations Committee, represent Psychiatry as trustee on the board of the Pennsylvania Medical Society and serve as an alternate delegate to the American Medical Association House of Delegates from the American Psychiatric Association (APA). The Pennsylvania Psychiatric Society is the district branch of the APA, and represents over 1,700 physicians across the Commonwealth who practice the medical specialty of psychiatry. We appreciate the opportunity to provide comments on this important issue.

The members of our governing council have carefully considered Senate Bill 226, weighing the arguments for and against the new criteria for voluntarily committing an individual via assisted community outpatient mental health treatment. As a Society, we have struggled with our position on this issue based on the complexity in determining when it is appropriate to petition for a patient's involuntary commitment.

Involuntary treatment is one of the most problematic aspects of the practice of psychiatry. The violation of the principle of patient autonomy and free choice can only be justified in extreme circumstances. We recognize that at times, the illnesses we treat interfere with the patient's ability to recognize that he is ill and in need of treatment. Even when patients lack insight in this way, however, there must be additional evidence that the lack of treatment will have dire consequences. There is no other way to justify taking charge of another person's life in such a manner.

Under the current Mental Health Procedures Act (MHPA) of 1976, the justification occurs when there is danger of serious injury or death to the patient himself, or others. This dangerousness standard has some detractors, who feel that the evidence required puts the patient and those around him at risk. It does not permit involuntary treatment until violent action has occurred.

Because of this requirement, and the perception that in some cases it is possible to reliably predict that progression of illness to violence is inevitable, many efforts have been made to intervene earlier. In particular, some states have enacted laws permitting a lesser standard of dangerousness, the so-called predictable deterioration standard, as grounds for intervention. This is the essence of the act before us, Senate Bill 226. It permits the courts, in certain defined circumstances, to identify patients who can be subject to police action if they fail to follow a prescribed treatment plan. It sets the bar to coerced care lower than it has been previously.

Our Society has had extensive discussions about Senate Bill 226, considering its roots as well as the likelihood that it will solve any of the problems which it purports to address. We have all considered our clinical practices, and how they might be helped or complicated by this bill. We have spoken with colleagues in New York, where Kendra's Law, on which this has been modeled, has been in effect for several years. We have debated whether such a bill might have had any effect in preventing the Virginia Tech tragedy.

These discussions have led us to conclude that Senate Bill 226 in its current form will not add sufficiently to our ability to treat patients effectively, to justify the problems that its enactment is likely to cause. While we are very aware of the many ways in which the current system fails to provide treatment to those who need it, we believe these failings would be better addressed in other ways.

Much of the effectiveness of Kendra's Law, and what is most appealing about Senate Bill 226, centers on the creations of assisted out-patient care teams, with careful evaluation and treatment planning. It holds the program directors accountable to the courts for the provision of care. It sets up the sort of teams which everyone involved knows are what is needed, but which currently lack the degree of funding and accountability which this bill envisions. It is our belief that essentially the same benefits can be accrued to patient care, without the addition of additional standards of involuntary commitment, by reworking the organization and funding of services to this vulnerable population.

An appealing aspect of Senate Bill 226 is the concept that we might be able to avoid involuntary inpatient care by making coerced care available as an outpatient. This provision is already contained in the MHPA, however, though it is variably practiced throughout the Commonwealth. Current law provides that the court can issue orders for involuntary treatment in a variety of settings, including outpatient. In some counties, sheriffs or police will show up at the home of a patient committed to outpatient care, who has failed to keep appointments, and escort him to the treatment site. There are a number of reasons why this has not been more widely practiced, chief among them issues of due process and procedure.

It is our belief that a more effective approach to the problem of patients who refuse care, would be to make use of the current MHPA, with specific regulations issued by the Department of Public Welfare, in the outpatient arena. All of the service provisions contained in the current bill could easily be applied under the MHPA, and make it as effective outpatient as it is inpatient. Explicit regulation, coupled with comprehensive outpatient teams, would do the job, without the problems inherent in changing the commitment standards.

Exactly what problems would occur, if we were to amend the MHPA, deserves attention. Our greatest concern is that the current consensus of what constitutes behavior meriting commitment would be lost. What would replace it is unclear. The dangerousness standard is fairly well defined. The standard for triggering police intervention as contained in section k(1) of SB 226 is far from clear. It relies on "the

clinical judgment of the [treating] physician” to determine that a patient, after failing to comply with assisted outpatient treatment, “may be in need of treatment under section 302 or 303”. What would lead a physician to come to such a conditional belief, is difficult to say. Is it any different than the current standard under the MHPA, which considers physicians, as well as law enforcement officers, to be able to sign 302 warrants without review by the county administrator or his delegates? Is there enough difference to change the law?

A related issue is more subtle, but also troubling. The current MHPA recognizes that certain behavior merits confinement in a controlled setting, until the underlying illness which is causing the behavior has remitted to the extent that the behavior will not recur. There is an implicit faith that such remission or recovery can occur. Assisted, or coerced, outpatient treatment, has at its core a much more pessimistic view- that illness will continue to a degree that will require coercion for an extended period. Psychiatrists are certainly very aware of the often chronic nature of the illnesses in our patients. We are very aware that our goal must be to help empower our patients to live as full a life as possible, and that what constitutes a full life must be as seen by the patient. Clearly there are many times when our patients chose to live very differently, but the principle of autonomy demands that we respect this, unless there is very compelling reason to intervene. The effect of Senate Bill 226 version of assisted outpatient care comes very close to substituting someone else’s judgment for what is a full life, without the dangerousness justification of our current law. I am extremely reluctant to take such a step.

It is our belief that the goals of Senate Bill 226 can be met by fully funding comprehensive assisted outpatient treatments. We also believe that the state should reserve the sort of coerced treatment as described in this bill, for the conditions which trigger our current Mental Health Procedures Act. The MHPA can be used to provide for care in an outpatient setting. If an effective solution to the problem of providing treatment exists, it lies in making that treatment available to individuals in a manner that provides continuity of care across the spectrum of their illness – in the preliminary phase, acute phase, partial remission, and complete recovery – not in broadening the criteria for voluntary commitment, which creates the potential for abuse and, even in the absence of abuse, allows an extraordinary intrusion into patients' lives. The mission of the Pennsylvania Psychiatric Society is to assist those individuals in the community suffering from mental illness and to assist in providing the adequate resources for them to thrive in their recovery. We applaud Senator Greenleaf for trying to address concerns of providing access to adequate outpatient treatment for those individuals needing mental health treatment and services, and extend our willingness to work on this important issue with him. We also look forward to working with members of this committee, House and Senate leadership, and specifically the Department of Public Welfare, to develop policies and procedures for the counties to use to better serve those patients in need of outpatient treatment.

Thank you for your time. Please let me know if you have any questions.