

**TESTIMONY OF CAROL HOROWITZ,
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Good morning. My name is Carol Horowitz and I am the Managing Attorney of the Disability Rights Network of PA (DRN), the organization that has been designated by the Commonwealth pursuant to federal law to advocate for and protect the rights of individuals with mental illness. I am also the parent and family member of individuals who have serious mental illness. On behalf of DRN and myself, I submit this testimony in strong opposition to S.B. 226 for two reasons. First, S.B. 226 reflects unsound mental health policy, using ineffective forced treatment as a panacea rather than addressing the fundamental issue that, due to consistent underfunding, there is a woeful shortage of available, appropriate mental health services for those who desperately need and want them. Second, S.B. 226 raises serious constitutional concerns, depriving individuals of their liberty without compelling reasons and without procedural protections.

Involuntary Outpatient Commitment Is Unsound Policy

Although outpatient commitment is available as a dispositional alternative to inpatient hospitalization under the current Mental Health Procedures Act,¹ S.B. 226 would allow involuntary outpatient commitment (which I will refer to as “IOC”) of individuals who do not present a clear and present danger to themselves or others. S.B. 226 would apply a lower standard to compel individuals who are not currently dangerous -- *and who may never have been dangerous* -- to comply with an outpatient treatment plan, including forced medication.

¹ 50 P.S. § 7103.

IOC appears to be premised on the idea that people with mental illness are non-compliant with treatment as a matter of choice. In fact, the real problem is not individuals' refusal of mental health services, but, rather, their inability to secure such services. In our Commonwealth, we have shown that people with mental illness can live safely in the community if they have access to a full array of medication, therapies, psychosocial rehabilitation, and supportive services (including housing and job programs) together with assertive outreach that assists them to identify and access services and supports. Indeed, the array of services and supports that individuals with mental illness need and that we know are effective already exist in many parts of Pennsylvania. Yet, there are many, many Pennsylvanians with mental illness who do not have needed services and supports due to consistent and severe underfunding of mental health services and due to the system's deficiencies in assuring continuity of care when individuals with mental illness are transitioned from one setting to another (such as from a community hospital setting to the community).

Public funding of mental health services for people living in the community has remained relatively stagnant. Despite the counties' annual requests for funds to expand community mental health services, they are rarely afforded the sums needed to do anything more than maintain services for those currently in service. As a result, virtually every county has a waiting list for community mental health services. Affordable and supported housing services for people with mental illness is particularly critical to enable people with mental illness to remain in compliance with treatment, but it is becoming increasingly difficult to

locate. Private funding for mental health services is even more scarce than public funding. Health insurance companies notoriously place restrictive caps on mental health services that are not placed on physical health care. The consistent underfunding, and in some cases defunding, of community mental health services makes it extremely difficult for individuals with mental illness to access the services they need to avoid hospitalization, homelessness, and other consequences of decompensation. By expanding funding to increase access to mental health services,² we could address the primary reason why people with mental illness are not receiving treatment, *i.e.*, because services are not available and not because services are refused.³

Another systemic problem affecting our mental health system is its fragmentation that undermines coordination of care.⁴ For example, individuals with mental illness who are discharged from hospitals or released from jails often had been taking specific medications that were helpful, but, when discharged, they cannot access those same medications and, in some cases, cannot access any medications because they lack health care benefits.

Rather than addressing the lack of funding for mental health care and the need for greater coordination of services, the Legislature is instead considering S.B. 226 as a panacea

² “Parity” legislation that requires private health insurers to afford equal coverage for physical and mental health care would go far toward expanding mental health funding by private health insurers.

³ See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 Psychol. Pub. Pol. & L. 107, 123-24 (2003)

⁴ See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 Psychol. Pub. Pol. & L. 107, 123 (2003).

to fix the mental health system. Studies show that IOC confers no benefits beyond providing individuals with access to effective community services -- access that more often than not would be unavailable if the individuals sought services on a voluntary basis.⁵ It is not surprising that individuals who receive intensive community services -- not merely forced medication -- tend to do better. IOC itself has no intrinsic benefits. Expanding service options and improving continuity of care would accomplish the same ends -- improving and increasing treatment -- without the coercion inherent in S.B. 226.

Moreover, S.B. 226 requires the provision of only negligible services. While S.B. 226 would require courts to adopt individualized treatment plans for persons subject to IOC, the only mandatory elements of the plan are case management *or* assertive community treatment (ACT).⁶ There is a fundamental difference between standard case management (which involves little oversight or outreach and where case managers can be responsible for 50 or more clients) and ACT that provides more intensive outreach services and lower caseloads. Beyond case management in some form, S.B. 226 makes no demands that the courts assure that individuals are provided with housing, job training, medical benefits, and other services that would facilitate compliance. Even New York's Kendra's Law -- the statute that is the clear forerunner of S.B. 226 -- included some funding for improved services and a grant program to assure continuity of medications for people transitioning from hospitals or

⁵ See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 Psychol. Pub. Pol. & L. 107, 121, 123 (2003); Bazelon Center for Mental Health Law, *Studies of Outpatient Commitment Are Misused* (July 3, 2001)

prisons.⁷ S.B. 226 makes no effort to address the real flaws that prevent individuals from accessing mental health services -- lack of funding and coordination. Indeed, there is no provision even to fund the case management services required by the statute, much less funding for housing and job programs. Without funding, it is guaranteed that individuals subject to IOC orders under S.B. 226 will be afforded only the most minimal services that will do nothing to help them onto the road toward recovery.

This leads to yet another unfortunate consequence that will undoubtedly flow if S.B. 226 is enacted. Because S.B. 226 is unfunded, individuals subject to IOC will be given priority in the allotment of scarce mental health resources. Families who are desperate for services for their loved ones may invoke S.B. 226 simply to jump ahead in the queue of people with mental illness who need those services. It simply is not rational to distribute scarce mental health resources in this way.

Another fundamental flaw in S.B. 226 is that it is coercive. We know that forced treatment simply does not work.⁸ Coercion inspires distrust of the treatment team, resentment, and lack of genuine cooperation.⁹ Coercion may get the person into treatment,

⁶ S.B. 226, § 305-A(f)(1)(i).

⁷ See New York State Office of Mental Health, *An Explanation of Kendra's Law* (Rev. May 2006); Paul S. Appelbaum, M.D., *Law & Psychiatry: Assessing Kendra's Law: Five Years of Outpatient Commitment in New York*, 56 *Psychiatric Services* 791 (July 2005).

⁸ See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 *Psychol. Pub. Pol. & L.* 107, 119-20, 121-22 (2003).

⁹ Under Sections 305-A(c)(1)(v) and 305-A(c)(3) of S.B. 226, the individual's treating psychiatrist or therapist can petition for IOC or testify in support of IOC. These provisions

but it does not guarantee that the person will benefit from such treatment and, to the contrary, is likely to make the individual reticent to voluntarily seek treatment in the future. By funding and making available an array of services that we know are effective -- including services such as ACT that actively engage people to participate in treatment -- the need for S.B. 226 will be eliminated because people will be able to access the services they need voluntarily in a manner that will be effective in the long run.¹⁰

Together with increased funding for expanded and coordinated community services, there are two other strategies that can go far toward assuring compliance without the need for the forced treatment mandated by S.B. 226. First, Pennsylvania enacted a mental health advance directive law two years ago.¹¹ Individuals with mental illness can execute a mental health advance directive when they are stabilized. These advance directives can authorize appropriate treatment in the event the individual can no longer make decisions for himself. Mental health advance directives assure that people receive the treatment they need when they are not able to make decisions for themselves even if the treatment is contrary to the

undermine the patient-psychotherapist privilege that has long been respected in Pennsylvania. This privilege is premised on the understanding that preservation of confidentiality of communications between an individual and his therapist can be crucial to recovery. Indeed, some individuals may forego treatment altogether rather than risk disclosure. The possibility that their therapists will breach confidentiality in an IOC proceeding may well make some individuals who would voluntarily accept treatment less likely to do so because they fear their confidences are at risk of public disclosure.

¹⁰ See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 Psychol. Pub. Pol. & L. 107, 120, 123 (2003).

¹¹ 20 P.S. §§ 5801-5845.

expressed wishes of the individual at the time treatment is delivered. Second, mental health courts can be an effective means to assure that individuals with mental illness who have been arrested and charged with petty crimes receive treatment. Individuals referred to a mental health court are persuaded to accept diversion from the criminal justice system in exchange for an agreement to participate in treatment. Treatment compliance is assured through behavioral contracting, reporting to the court on treatment progress, encouragement, and, if there is non-compliance, sanctions. Currently, a mental health court is successfully operating in Allegheny County and a few other Pennsylvania counties. This appears to be a model that can be replicated elsewhere.¹² Together, expansion of the use of advance mental health directives and mental health courts provide options to encourage treatment compliance in a way that is far less coercive than IOC and, therefore, more likely to be successful in the long term.¹³

Involuntary Outpatient Commitment Raises Serious Constitutional Concerns

S.B. 226 reflects not only poor policy, but also a fundamental disregard of the constitutional rights of individuals with mental illness. Specifically, S.B. 226 appears to be

¹² See Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 Psychol. Pub. Pol. & L. 107, 124-30 (2003).

¹³ As evidenced by New York's experience under Kendra's Law, IOC laws also raise issues about fundamental fairness. A study of the implementation of Kendra's Law after five years showed that African-Americans and Hispanics were significantly more likely to be subject to IOC orders than whites and that those differences were not explained by racial distribution of individuals with serious and persistent mental illness. The study also reflected that the vast majority (85 percent) of IOC orders were based on the individuals' histories of hospitalizations rather than histories of violence. New York Lawyers for the Public Interest, *Implementation of "Kendra's Law" Is Severely Biased* (Apr. 7, 2005).

inconsistent with the substantive and procedural protections afforded by the Due Process Clause of the Fourteenth Amendment of the Constitution.

The substantive due process concerns raised by S.B. 226 stem from its significant deprivation of the liberty of individuals with mental illness without justification. Individuals subject to IOC orders are forced to comply with treatment plans that significantly limit their liberty. For example, IOC orders will force psychotropic medication on individuals who may not want to take it because of the debilitating side effects and may force individuals to go to therapy or counseling at locations that are far from their homes and cannot be easily reached. S.B. 226 compromises these important liberty interests in the following ways that may well violate individuals' substantive due process rights.

- **Standards for Commitment Are Not Based on Valid Police Powers or *Parens Patriae* Authority**

States may constitutionally subject individuals with mental illness to involuntary treatment only if it is consistent either with their police powers or their *parens patriae* authority. A state's police power can justify involuntary treatment only if the individual is determined to be dangerous to himself or others.¹⁴ A state's *parens patriae* authority can justify involuntary treatment if the individual lacks decision-making capacity.¹⁵

¹⁴ See *Kansas v. Crane*, 534 U.S. 407, 409-10 (2002); *O'Connor v. Donaldson*, 422 U.S. 563, 574-76 (1975).

¹⁵ See *Project Release v. Prevost*, 722 F.2d 960, 978 (2d Cir. 1983).

S.B. 226's authorization of involuntary treatment is neither justified by the Commonwealth's police power nor its *parens patriae* authority. S.B. 226 allows involuntary treatment without proof that the individual is dangerous to himself or others. Indeed, Section 305-A(b)(4)(i) allows the involuntary treatment of a person who has no history of dangerousness but, instead, simply has been subject to two hospitalizations -- for whatever reason -- in the last three years.¹⁶ S.B. 226 also cannot be justified by the Commonwealth's *parens patriae* authority because it allows for involuntary treatment without any determination that the individual is not competent to make decisions.¹⁷

■ Right to Refuse Treatment

¹⁶ The criteria for involuntary treatment in Section 305-A(b) are also inconsistent with due process and unconstitutionally vague because it authorizes IOC orders based on speculation that the individual is "unlikely to survive safely in the community" and is "unlikely to voluntarily participate in the recommended treatment" An individual should not be stripped of his liberty interests based on clinical predictions of future possibilities. The criteria are not clear and will lead to arbitrary orders of involuntary treatment. Most troubling is Section 305-A(b)(6) that requires a finding that the individual needs IOC "to prevent a relapse or deterioration which would be likely to pose a clear and present danger of harm to others or to himself as determined under section 301." Section 301 of the Mental Health Procedures Act requires overt evidence that, within the last 30 days, the individual has acted in a way that constitutes a clear and present danger of harm to himself or others. Accordingly, Section 305-A(b)(6) establishes a standard that makes no sense. In effect, Section 305-A(b)(6) requires evidence that treatment is needed to prevent deterioration that would have resulted in overt acts of dangerousness within the past 30 days. This criterion -- which is internally inconsistent -- is unlikely to pass constitutional muster.

¹⁷ There are many situations in which individuals' behavior may conceivably pose dangers to society, but Pennsylvania has not -- and would not -- force preventative treatment in order to avoid future detention. For example, we do not allow people to petition for the forced outpatient treatment of individuals who are alcoholics or drug abusers simply because they may in the future engage in acts (such as driving under the influence) that would endanger others. So, too, we do not require individuals who are HIV-positive to take sex-drive reducing hormones to avoid the risk of reckless endangerment of others through unsafe sex. Why, then, is it permissible to force treatment of persons with mental illness who are not presently dangerous to themselves or others based on speculation of future risk?

Psychotropic medications not only intrude on bodily integrity and individual autonomy, but their direct and side effects also can cause serious mental and physical harm. The Supreme Court has recognized that even *inmates* and *pretrial detainees* with mental illness -- individuals legitimately in state custody -- have liberty interests in avoiding forcible medication that cannot be deprived without evidence that the state has a vital interest that supports involuntary administration of psychotropic medications.¹⁸ Generally, this would require a showing that the inmate is both mentally ill and gravely disabled or dangerous.¹⁹ The Court of Appeals for the Third Circuit in *Rennie v. Klein*, too, recognized that forcible medication of a state hospital resident in a non-emergency context would infringe on his liberty interest and held that forcible medication in such circumstances is permissible only if the physician determined that such medication was necessary to prevent the person from endangering himself or others.²⁰ The forced medication policy adopted by DPW for Pennsylvania state hospital residents follows *Rennie* and allows forced medication only in circumstances in which the resident poses a danger to himself or others.²¹ S.B. 226 would authorize orders that require individuals to comply with treatment regimens -- including

¹⁸ See *Riggins v. Nevada*, 504 U.S. 127, 134 (1992); *Washington v. Harper*, 494 U.S. 210, 221-22 (1990).

¹⁹ See *Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Washington v. Harper*, 494 U.S. 210, 227 (1990).

²⁰ *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded in light of Youngberg v. Romeo*, 458 U.S. 1119 (1982).

²¹ OMHSAS Bulletin No. 99-85-10 (1985).

administration of psychotropic medications -- or face serious consequences, such as arrest and hospitalization. S.B. 226, however, does not require *any* evidence that the individual represents an actual danger to himself or others so as to provide the compelling reason necessary to override the individual's interest in not being forcibly medicated. By imposing *de facto* forcible medication of individuals who are not dangerous, S.B. 226 appears to violate substantive due process.

- S.B. 226's Involuntary Hospitalization Provisions Allow Indefinite Detention and Lack Appropriate Standards.

Section 305-A(k) authorizes what appear to be two separate standards and processes for involuntary hospitalization. Both infringe on individuals' substantive and procedural due process rights.

Section 305-A(k)(1) provides that, if the individual does not comply with the IOC order, the physician can request the director to remove the individual to a hospital for an examination to determine if he "has a mental illness for which hospitalization is necessary."²² This subsection does not impose any limits on the time for which the individual can be hospitalized for non-compliance or allow judicial review. Detention for any period -- much less the *indefinite* detention authorized by Section 305-A(k)(1) -- constitutes a severe deprivation of an individual's liberty that cannot be justified by mere non-compliance with a

²² Section 305-A(k)(2) identifies what the physician may consider in determining whether such an examination is needed. Section 305-A(k)(3) authorizes the physician or director to direct law enforcement officials to take the individual into custody and transport him to a hospital for examination.

treatment plan. By allowing for indefinite confinement without any judicial review for non-compliance, this provision would certainly violate the Due Process Clause.

Section 305-A(k)(4) provides that, upon the request of the physician or director, the court may authorize the individual to be taken into custody and transported to a hospital for up to 72 hours to determine whether the individual has mental illness and needs involuntary treatment under the Mental Health Procedures Act. Section 305-A(k)(4) bars confinement beyond 72 hours except in accordance with the procedures for involuntary commitment under the Mental Health Procedures Act. Section 305-A(k)(4) seems to allow a 72-hour involuntary detention for any reason or no reason at all. It does not require any determination by the physician or director that the individual is non-compliant with the IOC or that he is dangerous to himself or others. The state cannot simply lock people up -- even for 3 days -- without a compelling interest. Even a short-term commitment, such as the 120-hour commitment authorized by Section 302 of the Mental Health Procedures Act,²³ is permissible only because the individual must be examined by a physician within two hours of arrival at the facility and determined at that time to have mental illness and to constitute a clear and present danger. By allowing individuals to be subject to confinement for three days without a compelling reason -- indeed, without *any* reason -- renders S.B. 226 constitutionally flawed.

S.B. 226 also includes overt violations of individuals' procedural due process rights. Procedural due process protections seek to minimize the arbitrary or erroneous deprivation of

²³ 50 P.S. § 7302.

liberty. The Fourteenth Amendment requires that, prior to deprivations of liberty such as that which would be imposed by IOC orders pursuant to S.B. 226, individuals must be afforded notice and an opportunity to be heard in a meaningful time and in a meaningful manner²⁴ and to legal representation.²⁵ The Fourteenth Amendment also requires that individuals have the opportunity to appeal IOC orders. Each of these procedural protections is sacrificed by S.B. 226.

■ Notice

Section 305-A(e)(2) of S.B. 226 provides that the court will advise the subject of the petition of the date for the hearing. There is no provision as to how much notice must be afforded. It is conceivable that the individual may receive less than three-days' notice, which is insufficient to prepare for the hearing and secure necessary evidence. Indeed, Section 305-A(e)(4) allows the hearing to proceed without the presence of the subject of the petition if "appropriate attempts to elicit" his attendance have failed. This vague standard combined with Section 305-A(e)(1)'s requirement that a hearing be held within three (3) business days of the petition undermines the ability of the subject of the petition to be present at the hearing and, accordingly, violates procedural due process.

The Due Process Clause requires that individuals receive not only notice of the hearing, but notice of the basis for the decision and its consequences. S.B. 226 does not

²⁴ See, e.g., *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976); *United States v. Ausburn*, ___ F.3d ___, 2007 WL 2580640 at *6 (3d Cir. Sept. 20, 2007).

²⁵ See, e.g., *Lassiter v. Dep't of Social Services*, 452 U.S. 18, 20 (1981); *In re Gault*, 387

require the court to inform individuals who are subject to IOC orders about the consequences if they fail to comply. This, too, contravenes the Constitution's procedural due process requirements.

■ Opportunity To be Heard

Section 305-A(e)(1) of S.B. 226 requires that hearings must be held within three (3) business days after the IOC petition is filed. This is constitutionally inadequate to allow the individual and his counsel to prepare and to secure witnesses and other evidence.

Constitutional concerns about the opportunity to be heard are heightened by the fact that the treatment plan, which must be in place prior to authorizing an IOC order, can be presented to the court at the time of -- or even *after* -- the hearing under Sections 305-A(f) and 305-A(g)(3). This procedure effectively precludes the individual and his counsel from reviewing it and securing evidence to address the plan prior to the hearing or, indeed, submitting any evidence to challenge the validity of the plan if it is presented after the hearing.²⁶

U.S. 1 (1967).

²⁶ It also appears that the court has no authority to revise the proposed treatment plan. Section 305-A(g)(2) states that the court “may not order treatment that has not been recommended by the examining physician and included in the treatment plan” If rejection of any part of the treatment plan means an inability to issue an IOC order, the court is likely to accept the treatment plan even if parts are problematic. This unconstitutionally undermines the individual’s ability even to present evidence that part of the treatment plan is inappropriate and should be modified. For example, the individual might have a specific reason to object to the inclusion of a particular medication due to side effects, but he would have no real opportunity to challenge that part of the plan because the court has no authority to reject any part of the plan.

In sum, although Section 305-A(e)(9)'s purports to allow the individual to present evidence and call witnesses, the timing of the hearing -- compounded by the fact that the individual may not have received even three-days' notice -- renders the opportunity to be heard illusory and contrary to the procedural due process protections of the Fourteenth Amendment.

- Right to Counsel

The right to counsel is a fundamental protection against the risk of erroneous deprivation of liberty. One of the most egregious constitutional violations in S.B. 226 is the failure to provide for appointed counsel for indigent clients. Section 305-A(d) provides for legal representation only "at the expense of the subject of the petition." There can be little doubt that most individuals who are subject to IOC petitions will be indigent and unable to afford counsel. The significant deprivation of liberty that results from an IOC order requires that the individual who is the subject of an IOC petition have the right to representation. Aside from the deprivation of liberty, advice of counsel is essential because Section 305-A(e)(3) permits the court to question the subject of the petition. Legal representation is critical to assure that the individual, if forced to testify under oath at such a hearing, understands his Fifth Amendment right to refuse to answer questions that may incriminate him. It is therefore constitutionally incumbent on the Commonwealth to appoint counsel for anyone subject to an IOC petition who cannot afford counsel. Indeed, the lack of authorization for appointed counsel in S.B. 226 appears unique among states that have

enacted IOC laws. New York's Kendra's Law, for example, includes the right to appointed counsel.²⁷

- Right to Appeal

Section 305-A(j) provides that "appeals shall be had in like manner as specified in section 303." Section 303 of the Mental Health Procedures Act, 50 P.S. § 7303, does not include any provisions for appeal, but, rather, only refers to reviews of the decision of a mental health review officer by a judge of the Court of Common Pleas. Accordingly, S.B. 226 seems to eliminate any right to appeal.

What Can Families Do?

I cannot conclude my testimony without acknowledging the very real pain and frustration that family members of people with mental illness face when their loved ones cannot secure needed care. As I mentioned in the beginning, I am a parent and family member of adults who have serious mental illness. I do not approach this issue in a civil libertarian vacuum. To the contrary, I have extraordinary empathy for the plight of the family members whose testimony you have heard today. My family has been in their situation and we understand the problems. Having said that, I also know that S.B. 226 -- or any other IOC statute that might be proposed -- is not the answer. It simply covers up the real problem relating to the lack of funding for services and the unnecessary fragmentation of the mental health system. It also is ineffective because forced treatment does not work. I can

²⁷ N.Y. Mental Hyg. Law § 9.60(g) (McKinney 2005).

say that speaking from experience. I have learned that when my children seek help voluntarily it is much more effective than when it is imposed upon them without regard to their unique needs.

Parents are not without resources. I encourage them to contact their county mental health offices to discuss what resources are available. I also encourage them to take advantage of local support groups that can link them to services, including peer services for their family members that can provide encouragement to seek necessary help. I would also suggest working with their loved ones to have them execute mental health advance directives when they are well that can be invoked if they later decompensate. Finally, I encourage them to urge support for more funding for an array of community mental health services, including ACT, housing, and job training.

Thank you.