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Pennsylvania Senate
Public Health and Welfare Committee
Hearing on Senate Bill 226

Testimony by: William S. Leopold, ACSW, MBA, Chief Administrative Officer
Montgomery County Emergency Service, Inc.
Norristown, PA

I am Bill Leopold, Chief Administrative Officer at Montgomery County Emergency Service. With me are Paul DeMarco R.N., Director of the Montgomery County Commitment Office, and Tony Salvatore, who is Director of Development at our facility and has expertise on suicide prevention.

Montgomery County Emergency Service (MCES) is a private, non-profit psychiatric crisis program that includes a 73-bed hospital. For over 30 years we have been the centralized crisis center for the county. MCES has received national recognition for its efforts of preventing the criminalization of the mentally ill. The program has become a model for other communities/states that are seeking improvement of the delivery of psychiatric emergency services, as most recently was requested by the task force Access to Services in Virginia.

We believe that involuntary outpatient commitment is, at times, necessary to engage consumers into receiving proper and necessary treatment. At MCES we frequently ask the court to authorize that some or all days available under a 303, 304, or 305 be used for outpatient commitment and we have seen good outcomes by the enforcement of the current law. We believe the current law is a good one but is vastly under-used across the state, and could be made much more effective. This will be the focus of these remarks.

First, a brief comment on SB 226, which we see as important in that it forces a dialogue on the topic. However, SB 226 creates a cumbersome system which is likely expensive, yet without any funding attached. It also appears to go counter to vital concepts of the principles of recovery, including empowerment. It appears to have more a focus on coercion than on engagement with the consumer.

Under the current code, Title 55, Chapter 5100, the ongoing treatment source is to be notified once an outpatient commitment is authorized. If a consumer is not following the order, the clinician can contact case management, or utilize whatever system the county administrator has authorized. In our experience, however, this is a rare event. Even in Montgomery County, which issues many outpatient orders, we have only a half-dozen 306 orders a year, which is the order to have consumers placed back into inpatient care. Private clinicians appear unaware of the regulations, or are resistant to using it. Some public clinics follow the regulations but many appear not to. Thus we have an under-used regulation whose effectiveness has never really been tested.

What follows below summarizes ideas on how to finally implement the existing law so that involuntary commitment can become a truly meaningful tool in helping persons with mental illness and those around them. Perhaps OMHSAS could convene a state-wide taskforce with a wide variety of stakeholders participating, to follow up on these strategies.

A Proposal on Creating Effective Enforcement of Current Laws Regarding Involuntary Outpatient Commitment

Private Sector

Professional licensees can be required to have trainings on commitments to get/renew licenses; and sign attestations that they are following all commitment laws.

Public Sector

OMHSAS convenes task force, then issues bulletin with clarification of current law and its proper implementation.

OMHSAS sets expectations on counties to enforce laws; sets quality improvement and/or pay-for-performance standards



Counties put standards into contracts with providers and perhaps MCOs, to be reviewed at contract renewals. This could include financial incentives, similar to ones which focus on consumers having appointments within seven days of hospital discharge.

County administrator has designee(s) (i.e., case management office at BSU) who must be notified of potential 306 by clinicians in both public and private sectors. Designee(s) are to be held accountable for contacting county officials responsible for commitment process.