

Senate Health & Welfare Committee
Senate Bill 226 - Assisted Outpatient Treatment
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Good morning Senator Erickson, Senator Hughes, Senator Greenleaf, Committee members and staff. Thank you for the opportunity to testify on Senate Bill 226 regarding "Assisted Outpatient Treatment." This bill would amend Pennsylvania's Mental Health Procedures Act by adding new procedures for obtaining involuntary outpatient commitment orders. Today's hearing is part of a broader, ongoing discussion on how we can make sure that persons with mental illness can recover and live safely in the community. I know that many friends and family members have shared their stories with you about the struggles they may encounter accessing treatment and community services for a loved one and believe that we share a common goal to make needed services more available.

Senate Bill 226 proposes a set of detailed procedures for obtaining involuntary outpatient commitment orders for "Assisted Outpatient Treatment" programs. Pennsylvania is one of 42 states that already has an outpatient commitment law on the books. The Pennsylvania Mental Health Procedures Act was enacted in 1976 and stipulates that "whenever a person is severely mentally disabled and in need of immediate treatment, he or she may be made subject to involuntary emergency examination and treatment, including outpatient treatment." The problem we face today is not that Pennsylvania doesn't have a law, but that Pennsylvania's law is not working well. By that I mean that it is not helping people get the treatment and services they need in times of crisis.

We know from our experience here in Pennsylvania as well as from other states that enacting an outpatient commitment statute in and of itself is not enough. Legislative change must be accompanied by stronger supports in the things people need to help them

stabilize and remain safely in the community. Two kinds of supports systems are critical to this process. First, we need multi-disciplinary case management teams with low staff to client ratios. I believe that ratios should not exceed the range of 10 to 15 clients per team member in order to realistically keep someone out of crisis. The case management team is charged with linking individuals with the range of services that may include psychiatric, social supports, medical, housing, employment or day activities, emergency services and other supports. These are the kinds of services that people need to stabilize and get back on the road to recovery.

Housing is the other key support system that must be in place. Some people with serious mental illness are also homeless or on the brink of a housing crisis. It is impossible to treat one issue and ignore the other. Absent a place to call home, people with mental illness will inevitably have trouble stabilizing their health, becoming self-sufficient or having positive relationships with family and friends. Pennsylvania has developed a comprehensive range of housing options. These options range from Long-Term Structured Residences (LTSR) to Independent Supported Housing. Long-Term Structured Residences accept individuals who are under commitment and have a psychiatrist on staff. Supported Housing models range from those with 24 hour in-house staffing to housing where staff are present at limited, specific times each week.

I came to Pennsylvania twenty years ago to oversee the closing of the Philadelphia State Hospital. My experience then is directly relevant to the topic before us today. One of the most effective thing that we did to help people transition from the institution to the community setting was create multi-disciplinary Community Treatment Teams (or CTTs). Each team is made up of a group of professionals including a half-time psychiatrist, a full-time nurse, three case managers, three case managers aides and a master's level team leader. The CTTs have responsibility for their clients 24 hours a day. They make contact seven days a week for new clients. The also work with community groups to make sure there are activities on evenings and weekends.

The case ratio was low – at the time we were closing Philadelphia State Hospital each Community Treatment Team was responsible for no more than 35 clients. The Hospital's closure is widely regarded as a success for both the individuals who were transitioned and the receiving communities. I believe that the system we developed of Community Treatment Teams is directly responsible for the positive outcomes. I also know that the low staff-to-patient ratios needed operate the Teams so effectively required and continue to require a significant and ongoing commitment of state resources.

The experience in New York also bears this out. New York has an Assisted Outpatient Treatment Law known as Kendra's Law that was passed in 1999. I believe that the drafters of Senate Bill 226 modeled much of their approach on New York's Kendra's Law including the criteria for invoking the court-ordered outpatient treatment provisions and procedures to use in the event of non-compliance.

While many states have enacted involuntary outpatient treatment statutes in recent years, New York took a different approach. Unlike other states that adopted outpatient commitment laws without also providing the increased costs of the associated services, the New York legislature passed legislation and provided the funding need to carry out the mandated assisted outpatient treatment programs. New York appropriated funds to expand case management and other services and to pay for the care of patients who are covered by Kendra's Law. In Fiscal Year 2005-2006, New York's state budget included more than \$32 million for operation of services specifically in support of Kendra's Law. More significant still is that the legislature also supported incremental funding each year since Kendra's Law passed back in 1999.

In short, New York recognized that it takes more than a law to change the system. It takes both a law and a sustained commitment to fund the intensive case management, supported housing and other required services. Pennsylvania is building this capacity via our statewide expansion of behavioral Health Choices. We are investing in our counties to develop treatment teams and community supports. In addition, DPW has hired a Housing Director. This individual who starts October 15 will coordinate housing efforts

with the PHFA so we can do a better job of leveraging dollars to create safe, affordable housing.

Another issue we are working to address is clients in the forensic system. This means clients with a mental illness and also have criminal charges. All of these clients need intensive case management when they exit the criminal justice system. The best example we have of this is in Lehigh County with their Assertive Community Treatment team.

Pennsylvania is in a fortuitous position right now to be able to learn from other states. Forty-two states currently have some form of involuntary outpatient commitment law and the experiences of these states vary widely. Several national studies are drawing to a close and I am directly involved in a number of these studies. The most significant analysis underway is a ten year review by the John D. and Catherine T. MacArthur Foundation comparing the effectiveness of mandated community treatment with non-mandated systems. The *Network on Mandated Community Treatment* was established to create a scientifically solid evidence base for developing effective policy and practice on whether and how to require certain people with mental disorders to adhere to treatment in the community. This initiative, now in its eighth year, is very comprehensive in its scope. We are reviewing the latest data on everything outpatient treatments modalities to mental health courts to case management strategies.

We know that laws alone don't work. We know that it will require significant resources to build the infrastructure we need and are very close to knowing what kind of services and supports are the most cost-effective and work best for individuals with mental illness and their families. I believe it makes the most sense to wait until the evidence is in before we change Pennsylvania law. I am willing to work with Senator Greenleaf and other co-sponsors to incorporate the results of this research into the legislation and associated programmatic changes.

Thank you and I am ready to take your questions.