REPORT ON THE MENTAL HEALTH SYSTEM AND LAWS OF PENNSYLVANIA

Including Source Notes and Comments to the Proposed Mental Health and Mental Retardation Code Title 50 (Mental Health) of the Pennsylvania Consolidated Statutes

Joint State Government Commission
Commonwealth of Pennsylvania
October 1987

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GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA
JOINT STATE GOVERNMENT COMMISSION
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October 1987

TO THE MEMBERS OF THE GENERAL ASSEMBLY

The Joint State Government Commission is pleased to present this report of the Task Force on Mental Health Laws. Chaired by Senator F. Joseph Loeper, the task force has directed codification of the Mental Health and Mental Retardation Code with revisions into Title 50 of the Pennsylvania Consolidated Statutes. The report includes a discussion of the proposed substantive revisions, studies of Pennsylvania's current mental health system, including a comparison with other states, source notes and comments and a disposition table to facilitate comparison with existing law.

The Commission wishes to express its appreciation to the members of the advisory committee, under the leadership of Ernest D. Preate Jr., Esq., for sharing their time and expertise. The Commission also wishes to express its gratitude to the staff of the Office of Mental Health, Department of Public Welfare, for their invaluable assistance.

Respectfully submitted,

Roger A. Madigan
Chairman

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Summary of Findings

Much of the testimony presented at public hearings held by the Task Force on Mental Health Laws focused on major problems in the mental health system and deficiencies in the mental health laws.

The Commission staff supplied extensive background material to the task force and advisory committee including a detailed description of Pennsylvania's public mental health operations. Summaries of numerous articles by mental health professionals were also provided. Findings drawn from the public hearings and staff's studies are summarized below.

1. Communication and coordination between the State hospital and community mental health systems is insufficient to ensure a full array of services in each locality.
2. Inadequate training contributes to inconsistent interpretation and implementation of the mental health laws.
3. Insufficient discharge planning and follow-up care is provided for persons discharged from mental health facilities.
4. A meager supply of community residential services is available.

5. Case managers have high case loads which may prevent them from providing individualized, intensive case management services to chronically mentally ill persons.

6. Some State hospitals may face loss of federal funds if accreditation standards are not met and maintained.

7. Restrictive views of confidentiality requirements prevent communication among mental health personnel, law enforcement personnel and family members.

8. The general public is uneducated as to symptoms, effects and causes of mental illness.

9. Advocacy for patients rights is in need of reinforcement.

10. Court procedures regarding involuntary treatment are inconsistently interpreted and overly restrictive.

11. The criteria for determining when involuntary treatment is required are so restrictive that substantial deterioration to the point of violent behavior is required before intervention may be authorized.

12. Patterns of behavior may be helpful in determining if a person's mental illness is recurring, but past medical history and behavior are currently not considered in deciding if involuntary treatment is necessary.

13. Initial examination periods are sometimes too short for adequate diagnosis.

14. Although involuntary outpatient treatment is generally authorized under the Mental Health Procedures Act, there

has been reluctance to use it because procedures were not explicitly set forth in the statute.

15. Services to persons incompetent to stand trial or serving sentence are difficult to administer.

16. Minimum qualifications for the position of Commissioner of Mental Health are needed.

17. Total funding for Pennsylvania's public mental hospital system in fiscal 1986-87 was $442.5 million, reflecting an average annual increase of 9.4 percent since fiscal 1970-71. State appropriations to mental hospitals amounted to $292.7 million or 66 percent of total funds supplied.

18. The patient population in State hospitals totalled 7,823 persons in 1986-87. Patient population has declined steadily since 1970-71, but the decline has recently slowed: the population dropped 50 percent from 1970-71 to 1977-78 and 36 percent from 1978-79 to 1986-87.

19. Staff positions have declined 30 percent in the period 1970-71 to 1985-86, resulting in a higher staff-patient ratio. Approximately two-thirds of the total staff serving the State mental hospital system are on the clinical staff.

20. Total funds per patient increased 146 percent from 1970-71 to 1986-87 (in constant 1984-85 dollars), while State funds increased 119 percent during the same period. Most of this growth in constant dollars occurred in the 1970-71 to 1977-78 time period.

21. During the past 7 1/2 years, the number of voluntary civil admissions has declined, while involuntary admissions have increased, so that 90.4 percent of all admissions to State hospitals in 1987 are involuntary civil and criminal admissions.

22. Total funding for the community mental health system in fiscal 1985-86 was $339 million; State funds comprised $107.6 million or 32 percent of the total.

23. Admissions to the community mental health program totalled 87,623 patients in 1985-86, including an estimated 23,600 readmissions. Total persons provided service in community programs was 221,000 that year.

24. Total expenditures in the community mental health system for fiscal 1984-85 included 8.9 percent for case management and 35 percent for inpatient services. Approximately 63 percent of all staff positions in the community system are clinical positions.

25. In fiscal year 1985 public mental health expenditures per capita amounted to $67.89 in Pennsylvania--second highest among all states. The national average expenditure rate was $41.62 per capita.

26. In fiscal 1985 Pennsylvania's total public mental health expenditures were divided as follows: State mental hospitals, 58 percent, the community-based system, 40

percent and support activities, 2 percent--a distribution similar to the national average distribution of total expenditures among these programs.

27. Pennsylvania's expenditures per mental hospital resident patient of $54,495 were 15 percent above the national average of $47,586 and rank Pennsylvania 12th among the states.

28. Pennsylvania's 1984 resident mental hospital population of 8,616 was equivalent to a rate of 73 resident patients per 100,000 civilian population. This rate is 52 percent above the nationwide average of 48 per 100,000 civilian population and ranks Pennsylvania seventh among the states.

29. Pennsylvania's 202-day average length of stay per mental hospital inpatient was more than double the United States 1983 average length of stay of 92 days and ranks Pennsylvania second among all states. An adjustment for the presence of an estimated 1,700 long-term care patients in Pennsylvania's public mental hospitals does not significantly reduce the State's ranking.

30. In 1983 Pennsylvania's mental hospital patient care staff per inpatient was .91. The ratio is 12.5 percent below the 1983 national average of 1.04, but this position may reflect the impact of long-term care patients who may not require as much clinical staff attention as the seriously

mentally ill. The limited variation in the care staff per inpatient ratio among states implies that significant changes in patient loads could be directly reflected in staff requirements.

Summary of Recommendations

The Task Force and Advisory Committee on Mental Health Laws recommend the enactment of legislation which would:

-- Consolidate mental health law into Title 50 of the Pennsylvania Consolidated Statutes.

-- Assure that services at State mental hospitals complement county-provided services (§ 301(9)).

-- Authorize formation of State hospital service area Conjoint Boards to provide joint planning at a regional level between State hospitals and county mental health programs (§ 313).

-- Require all inpatient facilities to make referrals to county programs for all discharged persons who receive publicly funded mental health services (§ 916).

-- Mandate case management and intensive case management services (§ 501(c)(10), (11)).

-- Require State hospitals to meet minimum accreditation standards (§ 301(9)).

-- Permit treatment personnel to communicate with family or household members of mentally ill persons in treatment for treatment purposes (§ 112(c)(1)).

-- Permit treatment personnel to release general information concerning a mentally ill person's status and general condition to the person's family or household members (§ 112(c)(2)).

-- Authorize disclosure of confidential records in compliance with the Federal Protection and Advocacy for Mentally Ill Individuals Act of 1986 (§ 112(b)(5)).

-- Assure the provision and funding of external advocates at State hospitals (§ 301(13)).

-- Require the Department of Public Welfare to coordinate with national and local efforts to combat stigma about mental illness (§ 301(14)).

-- Encourage consumer and family-operated self-help groups and alternative programs (§ 301(15)).

-- Incorporate a patients' bill of rights into statutory law (§ 2503).

-- Mandate the establishment of statewide training for personnel involved in the delivery of mental health services (§ 301(6)).

-- Change training at the county level from an optional service to a mandated one (§ 501(c)(13), (d)) and include it in the 100 percent Commonwealth funding category (§ 127(6)).

-- Specify benefit periods for different levels of partial hospitalization services (§ 127(3)).

-- Remove inpatient care from the 100 percent Commonwealth funding category (§ 127(3)).

-- Add residential services to the 100 percent Commonwealth funding category (§ 127(5)) and to mandated county services (§ 501(c)(12)).

-- Encourage county programs to seek charitable donations by not including them in the determination of the Commonwealth's obligation (§ 129(1)).

-- Encourage the use of purchase of service contracts to provide services (§ 501(e)).

-- Specify three levels of partial hospitalization services to be made available in county programs (§ 501(c)(3)).

-- Remove detailed descriptions of required county-provided services (§ 501(c)(5)-(7)).

-- Create a Bureau of Admissions Services to coordinate and supervise admissions and serve as a central office to coordinate services between the mental health and corrections systems (§ 303).

-- Add injury to property to types of dangerousness (§ 1301(a)).

-- Add past behavior and medical history as relevant evidence in determining if involuntary treatment is necessary (§ 1301(a)).

-- Expand from 30 to 60 days the period during which behavior may be considered in determining if involuntary treatment is necessary (§ 1301(b)).

-- Remove "serious" from "bodily harm" in determining if there is a danger of harm to others (§ 1301(b)).

-- Toll the 60-day period for considering behavior when a person has been detained because of pending criminal charges (§ 1301(b)).

-- Remove "death" and "serious" from bodily injury in determining if there is a danger of harm to self (§ 1301(c)).

-- Add threats coupled with past behavior to criteria for determining dangerousness (§ 1301(d)).

-- Change maximum period for emergency examination and treatment from 120 hours to five business days (§ 1302).

-- Add licensed, doctoral-level psychologists to persons authorized to initiate emergency examination (§ 1302).

-- Permit the use of statements from a person believed to be subject to involuntary treatment to authorize emergency examination without a warrant (§ 1302(c)).

-- Remove requirement that facility directors perform certain duties and place those duties on county administrators (§ 1302(f)).

-- Specify involuntary outpatient treatment procedures (§§ 1302(g), 1306(d), 1307).

-- Clarify that a certification by a mental health review officer is to be treated as a final order, subject to appeal (§ 921(a)).

-- Remove language requiring a showing of dangerous conduct during treatment before additional periods of treatment can be authorized (§ 1305).

-- Specify arson-related offenses and attempts to commit any of the enumerated offenses in provisions authorizing court-ordered involuntary treatment for up to one year (§ 1304(g)).

-- Permit the transfer of persons competent to stand trial or serving sentence from five-day emergency treatment to 90-day court-ordered treatment without an intervening 20-day extended emergency treatment or before the 20-day treatment has expired (§ 1501).

-- Change the requirement that the least restrictive alternative consistent with "adequate" treatment be used to the least restrictive alternative consistent with treatment "appropriate to the individual's needs" (§ 902).

-- Authorize the release of information to police in emergency situations (§ 112(c)(3)).

-- Permit treatment personnel to warn threatened persons or police of threats (§ 112(c)(4), (5)).

-- Require facilities to notify police of the pending release of persons not accepted for emergency treatment, when the police brought the person to the facility and have requested the notice (§ 1302(d)).

-- Add training and education qualifications for the position of Commissioner of Mental Health (§ 302(a)).

-- Authorize the appointment of a Deputy Commissioner for Clinical Services and set forth the qualifications for the position (§ 302(b)).

The majority of the task force adopted these recommendations; however, Senator Williams and Representative Josephs objected to certain proposals and their dissenting statements are set forth in Part V.

I. Introduction

The General Assembly of Pennsylvania in 1985 Senate Resolution No. 108 directs the Joint State Government Commission to organize a legislative task force to "undertake a comprehensive review of the Mental Health Procedures Act and the Mental Health System in this Commonwealth." Pursuant to the authorizing resolution, a task force, chaired by Senator F. Joseph Loeper, was appointed. The authorizing resolution created an advisory committee to the task force, consisting of the Attorney General, the Secretary of Health, the Secretary of Public Welfare and other individuals deemed appropriate by the task force. The task force appointed 17 additional members to the advisory committee to assist it in its study and named Ernest D. Preate Jr., Esq. to serve as chairman. These individuals, all highly experienced in the field of mental health, represented a diversity of viewpoints as well as geographical areas of the Commonwealth.

In order to fulfill its mandate under the resolution, the task force conducted a series of six public hearings throughout the State. Beginning in July 1986 and ending January 1987, the task force heard testimony from over 120 witnesses at hearings in Pittsburgh, Altoona, Media, Philadelphia, Scranton and Harrisburg. Another 30 persons submitted written statements to the task force. These witnesses

included consumers of mental health services, family members, advocates, psychiatrists, psychologists, social workers, nurses, therapists, service providers, county administrators, union representatives of persons working in the public mental health system, attorneys, legislators, local government officials, mental health review officers, law enforcement officials, including police officers, district attorneys and prison wardens, as well as other interested parties. See appendix A for the listing of these witnesses.

Over 500 recommendations were received concerning commitment procedures, service delivery, funding, patients' rights and related issues. Most of the recommendations advocated some type of reform of the current mental health system and laws.

The Advisory Committee on Mental Health Laws first met in December of 1986 to begin reviewing the recommendations received at the hearings as well as materials submitted by Commission staff, members of the advisory committee and other interested persons.

In order to more expeditiously review these materials, the committee was divided into four topical subcommittees: the Subcommittee on Patients' Rights, the Subcommittee on Funding, the Subcommittee on Service Delivery and the Subcommittee on Commitment Procedures.

Throughout the spring and summer of 1987 the advisory committee met on a regular basis, both in full committee and in subcommittees, to prepare a package of recommendations to the task force.

The legislative recommendations of the task force and advisory committee have been incorporated into a proposed Mental Health and Mental Retardation Code to be included in Title 50 of the Pennsylvania Consolidated Statutes. The Code contains the provisions of all Pennsylvania statutory law relating to mental health, as well as those provisions of the Mental Health and Mental Retardation Act of 1966 that relate to both mentally ill and mentally retarded persons. Other relevant Pennsylvania statutes and regulations and Pennsylvania and federal court decisions were examined to ensure that the Code accurately reflects the current state of Pennsylvania law. Except where specific proposed amendments of the task force and advisory committee are indicated in the Summary of Findings and Recommendations, this codification does not substantively change the current law. The proposed Code has been put in a form consistent with the editorial practices and format of the Pennsylvania Consolidated Statutes, which has necessitated editing and section renumbering.

Part II of this report provides a legislative history of Pennsylvania's mental health laws. Part III provides a description of the State mental hospital and community mental health programs in Pennsylvania and sets forth data on funding, patients, staffing, admissions and services for those programs. Part IV provides an interstate comparison of state mental health operations, including total mental health expenditures, state mental hospital expenditures, inpatient censuses, staffing complements and lengths of inpatient

stays in all 50 states. Part V discusses the bases of the recommendations of the task force and advisory committee. Part VI contains source notes for each section of the Mental Health and Mental Retardation Code and, where pertinent, official comments of the Task Force and Advisory Committee on Mental Health Laws. The table contained in appendix A lists the witnesses at each public hearing as well as those persons who submitted statements directly to members of the task force or to Commission staff. Appendix B provides a disposition table which cross references existing law with proposed Title 50. Appendix C contains a bibliography of materials used by the task force, advisory committee and Commission staff in this study.

II. Legislative History

In 1951, Pennsylvania enacted its first comprehensive statute providing for the care and treatment of mentally ill and mentally retarded persons. The Mental Health Act of 1951 (act of June 12, 1951, P.L.533, No.141) created a State system of institutional care centered in State hospitals and schools. Prior to that enactment, mental health services were governed by over 50 acts or part of acts that frequently addressed issues other than mental illness or mental retardation.

In 1963, the U.S. Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164, 77 Stat. 282) which authorized federal grants to states to assist them in constructing community mental health centers. This enactment provided the financial incentive for many state legislatures to provide mental health services in the community. In Pennsylvania, this incentive, coupled with a nationwide trend toward "deinstitutionalizing" mental patients, led the General Assembly to enact the Mental Health and Mental Retardation Act of 1966 (act of October 20, 1966, 3rd Sp. Sess. P.L.96, No.6). This act was the product of a two-year statewide study conducted by the Comprehensive Mental Health Study Commission. The study commission, a

Department of Welfare project funded by a $2 million federal grant, consisted of a number of task forces appointed by the Secretary of Welfare and the Commissioner of Mental Health. In an effort to encourage community involvement and solicit grass roots input, the department involved over 3,500 people in the project. The project's final product was intended to provide a comprehensive system for the coordinated delivery of mental health services at the State and county level with an emphasis on community services. However, during the early 1970s, several provisions of article IV of the 1966 act, which provided for voluntary and involuntary commitment and treatment of the mentally ill and mentally retarded, were declared unconstitutional by State and federal courts. See e.g., Dixon v. Attorney General of Commonwealth of Pa., 325 F.Supp. 966 (M.D. Pa. 1971), Commonwealth ex rel. Finken v. Roop, 234 Pa. Superior Ct. 155, 339 A.2d 764, cert. denied 424 U.S. 960 (1975) and Goldy v. Beal, 429 F.Supp. 640 (M.D. Pa. 1976).

Beginning in 1971, and through 1976, legislation was introduced to address the issues raised in these court cases. Finally, in 1976, after extensive hearings before the Senate Public Health and Welfare Committee, chaired by Senator W. Louis Coppersmith, the General Assembly enacted the Mental Health Procedures Act (act of July 9, 1976, P.L.817, No.143) which was intended to address many of the concerns regarding mentally ill persons raised in the court cases. Much of the drafting of this act was prepared by an ad hoc committee organized by Senator Coppersmith for that purpose.

The 1976 act repealed many of the provisions of article IV of the 1966 act except insofar as they related to mental retardation or mentally retarded persons so that admissions and commitments of mentally retarded persons under current law are governed by a combination of the 1966 act, case law and regulations of the Department of Public Welfare.

The 1976 act was substantially revised in 1978; these amendments were subject to public comment at hearings conducted by the Senate Public Health and Welfare Committee. Two other minor amendments were made in separate acts in 1978 and 1980. Over 45 other proposals to amend the act have been introduced in, but not adopted by, the General Assembly.

III. Pennsylvania's Public Mental Health System

Public mental health services in Pennsylvania are provided through two major systems--the State-operated mental hospital service system and the community mental health service system. The two programs together offer a continuity of services designed to help the mentally ill as early as possible at the community level in order to avoid institutional care which is both more restrictive and more expensive.

State hospitals provide long-term and specialized inpatient care for the chronically mentally ill based on a prevention model that incorporates resident treatment and rehabilitative services designed to enable most patients to be discharged. State hospitals are required to refer discharged persons to the county mental health system in order to assure continuity of care.

The community mental health system consists of a number of types of facilities including psychiatric inpatient services in community general hospitals, private psychiatric hospitals, personal care boarding homes, community residential rehabilitative centers and similar facilities. Community programs provide short term treatment services, crisis intervention, outpatient and partial hospitalization services, residential services, social and vocational rehabilitation

and case management services. These services are directed toward prevention of psychotic episodes as well as prevention of long-term hospitalization.

Community inpatient psychiatric facilities are generally responsible for emergency examination and treatment. If a community bed is not available, referrals can be made to the State hospital under procedures usually established in letters of agreement between the county program and the State hospital.

Persons charged with crime or under sentence generally receive treatment in psychiatric units of prisons, State mental hospitals or Farview State Hospital.

STATE MENTAL HOSPITAL SERVICE SYSTEM

The State mental hospital system presently consists of 15 State mental hospitals and one restoration center. Two of the 15 hospitals serve special patient populations and 13 are general purpose mental hospitals. The general purpose hospitals are: Allentown, Clarks Summit, Danville, Harrisburg, Haverford, Mayview, Norristown, Philadelphia, Somerset, Torrance, Warren, Wernersville and Woodville.

One of the special patient hospitals is Farview State Hospital, a maximum security facility, serving mentally ill offenders or defendants; the other is Eastern State School and Hospital which serves mentally ill children and adolescents needing longer treatment

than is available at the community level. The one restoration center, South Mountain, furnishes licensed skilled nursing and intermediate long-term care services to elderly former mental hospital patients who cannot be placed in community nursing beds.

All general purpose State mental hospitals provide intensive psychiatric rehabilitation services for patients who need intermediate and long-term inpatient care on a 24-hour basis. Each hospital serves a designated community service area based on: current and historical patterns and rate of usage by surrounding communities, accessibility and distance, capacity to provide service, and input from hospitals and county mental health/mental retardation program units.[1] Twelve of the hospitals are accredited by the Joint Commission on Accreditation of Hospitals, 15 are certified by Medicare and 10 of the hospitals, as well as the South Mountain Restoration Center, are certified as long-term care providers.[2]

The State mental hospital system is operated by the Office of Mental Health, Department of Public Welfare, and each hospital has a nine-member citizen advisory board of trustees whose members are appointed by the Governor and confirmed by the State Senate.

Funding for the State mental hospitals is provided by State appropriations, federal funds and collections from other sources which include payments by clients or legally responsible relatives, private

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[1]Pa. Department of Public Welfare, Office of Mental Health, 1986-89 Mental Health Plan and 1985-86 Annual Report, Volume 1, p. 2-2.

[2]Ibid., p. 4-2.

insurance, pension payments and payments by counties for care of forensic patients.

Table 1 shows State, federal and other funds provided to the State mental hospital system for the fiscal years 1970-71 through 1986-87. Total funding has grown from about $176 million in fiscal 1970-71 to $442.5 million in 1986-87--a 151 percent increase or an average annual increase of 9.4 percent over the 16 years. State funds have increased from $131 million to $293 million over the same period, an increase of 124 percent. Federal funds have grown from $24 million to $110 million, an increase of 358 percent or an average annual rate of 22 percent. Most of the growth in federal funding took place during the 1970-71 through 1982-83 period. Other funds have increased from $21 million in 1970-71 to $40 million in 1986-87 or about 90 percent over the period.

Table 2 illustrates the historical time paths of total patient population and filled staff positions. The number of patients has declined from 25,244 in 1970-71 to 7,823 in 1986-87, a 69 percent decrease. In recent years the decline in patient population has slowed: the population dropped by one-half in seven years (from 25,244 in 1970-71 to 12,290 in 1977-78) and by 36 percent over the nine years ending 1986-87.

The number of staff positions has not declined proportionately to the decline in patient population. From 17,124 in 1970-71, the number of staff declined to 11,976 in 1985-86 or a reduction of 30 percent over the 15-year period, in contrast to the 67 percent

Table 1

STATE, FEDERAL AND OTHER FUNDS
PROVIDED TO STATE MENTAL HOSPITALS
AND RESTORATION CENTERS
FISCAL YEARS 1970-71 THROUGH 1986-87
(dollar amounts in 000's)

Fiscal year	Source of funds State	Federal	Other*	Total
1970-71	$130,847	$24,107	$20,605	$175,559
1971-72	139,263	33,770	19,877	192,910
1972-73	159,811	35,803	24,588	220,202
1973-74	176,095	39,894	26,063	242,052
1974-75	196,151	48,401	25,204	269,756
1975-76	215,629	55,154	18,285	289,068
1976-77	198,488	85,470	21,593	305,551
1977-78	226,724	81,429	20,476	328,629
1978-79	232,866	83,439	26,095	342,400
1979-80	244,929	81,625	31,761	358,315
1980-81	255,827	88,302	26,493	370,622
1981-82	269,020	105,823	31,624	406,467
1982-83	288,813	119,095	38,735	446,643
1983-84	288,437	114,844	39,426	442,707
1984-85	305,881	108,450	39,585	453,916
1985-86	304,578	121,574	37,248	463,400
1986-87	292,691	109,952	39,889	442,542

*Other--consists of client liability, 39 percent; private insurance payments, 12 percent; county liability for forensic patients, 41 percent and payments by legally responsible relatives and miscellaneous payments such as black lung pensions, 8 percent. The percentages are based on actual institutional collection reports for six months in 1985-86 fiscal year, provided by the budget office of the Pa. Department of Public Welfare.

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years.

Table 2

PATIENT POPULATION
AND FILLED STAFF POSITIONS
IN STATE MENTAL HOSPITALS
AND RESTORATION CENTERS
FISCAL YEARS 1970-71 THROUGH 1986-87

Fiscal year	Filled staff positions	Patient* population
1970-71	17,124	25,244
1971-72	17,393	22,295
1972-73	17,024	20,194
1973-74	16,752	18,865
1974-75	16,224	16,599
1975-76	15,667	15,069
1976-77	15,148	13,569
1977-78	15,023	12,290
1978-79	15,125	11,634
1979-80	14,274	11,565
1980-81	14,146	11,001
1981-82	13,870	10,727
1982-83	13,603	10,465
1983-84	13,278	9,687
1984-85	12,912	9,398
1985-86	11,976	8,364
1986-87	na	7,823

*Patient count is as of October except for the period 1984-85 through 1986-87 which is based on the July count. The patient count for July 1987 was 7,743.

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years; and Pa. Department of Public Welfare, Office of Hospital Services.

reduction in patients over the same period. The resulting increase in the staff-patient ratio is attributed in part to the standards necessary to meet accreditation and federal requirements necessary to qualify for medical assistance funding. Also it is maintained that high staffing ratios are required to effectively treat a more seriously ill population and to provide specialty services to the forensic, children and youth populations.

Table 3 shows total and State funds per patient and total and State funds per patient in constant (1984-85) dollars. Constant dollar calculations were made using the medical-care component of the U.S. Consumer Price Index.

Although total current funds per patient increased from $6,954 in 1970-71 to $56,569 in 1986-87 or by 713 percent, total constant dollar funds per patient grew from $21,856 to $53,875, an increase of only 146 percent over the same period.

State funds per patient for the same period grew from $5,183 to $37,414, an increase of 622 percent. State funds per patient in constant (1984-85) dollars increased 119 percent from $16,290 to $35,632 in 1986-87. Most of the increase in State and total funds per patient in 1984-85 dollars took place during the 1970-71 through 1977-78 time period. The inflation adjusted State funds per patient in fiscal 1986-87 of $35,632 are slightly above the level attained in fiscal years 1977-79.

Table 3

TOTAL AND STATE FUNDS PER PATIENT
AND TOTAL AND STATE FUNDS PER PATIENT
IN 1984-85 DOLLARS
STATE MENTAL HOSPITALS AND RESTORATION CENTERS
FISCAL YEARS YEARS 1970-71 THROUGH 1986-87

Fiscal year	Total funds per patient	Total funds per patient in 1984-85 dollars	State funds per patient	State funds per patient in 1984-85 dollars
1970-71	$6,954	$21,856	$5,183	$16,290
1971-72	8,653	25,951	6,246	18,732
1972-73	10,904	31,586	7,914	22,925
1973-74	12,831	34,856	9,334	25,356
1974-75	16,251	39,842	11,817	28,971
1975-76	19,183	42,489	14,309	31,694
1976-77	22,518	45,514	14,628	29,566
1977-78	26,740	49,613	18,448	34,228
1978-79	29,431	50,164	20,016	34,116
1979-80	30,983	47,947	21,178	32,773
1980-81	33,690	47,040	23,255	32,470
1981-82	37,892	47,581	25,079	31,492
1982-83	42,680	48,691	27,598	31,485
1983-84	45,701	48,543	29,776	31,628
1984-85	48,299	48,299	32,547	32,547
1985-86	55,404	51,779	36,415	34,033
1986-87	56,569	53,875	37,414	35,632

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years. Total and State funds per patient are calculated from tables 1 and 2. Funds per patient in 1984-85 dollars are calculated by adjusting the expenditures to reflect the price level for medical care based on an index of 1984-85 = 100 as indicated by the medical-care component of the Consumer Price Index published by The Council of Economic Advisors, The Economic Report of the President, February 1986 and 1987.

Funds Provided, Patients and Staff in State Mental Hospitals And Restoration Centers by Facility

The number of State mental hospitals and restoration centers has declined from 22 in 1970-71 to 16 in 1986-87 due to facility closing or conversion to other uses.

The following six State mental health facilities have changed status:

Dixmont--closed in 1983-84

Embreeville--converted to a mental retardation center in 1978-79 (A small number of mental health patients remained there through 1982-83)

Hollidaysburg--transferred to the Department of Military Affairs in 1978-79

Retreat--closed in 1980-81

Eastern Pennsylvania Psychiatric Institute--operation contracted to the Medical College of Pennsylvania in 1980-81

Western Restoration Center--closed in 1984.[3]

Table 4 shows total funds provided for State mental hospitals and restoration centers by facility at two-year intervals from the 1970-71 fiscal year through 1986-87 and the percentage change in funds provided over the 16-year period.

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[3]Department of Public Welfare Memorandum "Fiscal and Patient Data - State Mental Hospital and Restoration Center for Senate Resolution 108 Task Force," May 22, 1986.

Table 4

TOTAL FUNDS PROVIDED FOR STATE MENTAL HOSPITALS AND RESTORATION CENTERS, BY FACILITY AT TWO-YEAR INTERVALS 1970-71 THROUGH 1986-87
(Dollar amounts in 000's)

Facility	1970-71	1972-73	1974-75	1976-77	1978-79	1980-81	1982-83	1984-85	1986-87	Percentage change 1970-71 to 1986-87
Allentown	$7,287	$9,864	$12,269	$14,210	$15,838	$17,980	$22,266	$22,871	$23,007	216%
Clarks Summit	5,120	6,697	8,359	9,989	13,315	17,005	22,490	24,425	23,799	365
Danville	8,906	11,359	14,724	18,015	20,099	22,752	29,487	30,588	28,246	217
Dixmont	4,295	5,486	6,906	8,101	9,247	11,003	12,998	527	a	-100
Embreeville	5,285	6,849	10,675	7,956	7,130	a	--	--	--	-100
Farview	6,014	7,674	9,748	11,810	12,285	15,674	18,796	20,969	22,193	269
Harrisburg	10,206	12,509	12,411	13,439	14,985	17,866	22,683	24,423	24,442	139
Haverford	6,478	8,320	10,794	12,892	15,331	18,994	23,733	24,520	25,085	287
Hollidaysburg	4,009	5,385	6,658	6,329	3,154	a	--	--	--	-100
Mayview	11,997	14,784	18,749	23,916	28,046	35,037	45,318	50,249	46,787	290
Norristown	15,375	18,898	25,460	30,713	36,719	42,598	50,844	52,044	51,533	235
Philadelphia	23,545	28,954	30,150	31,707	33,377	37,439	38,167	38,656	39,016	66
Retreat	4,562	6,102	7,607	8,468	8,296	4,592	a	--	--	-100
Somerset	3,537	4,412	5,048	5,899	7,319	10,480	13,477	13,854	14,018	296
Torrance	10,165	12,168	14,795	16,633	20,156	20,904	26,272	26,926	24,694	143
Warren	11,150	13,498	16,263	17,872	20,045	22,880	29,772	30,612	29,484	164
Wernersville	6,877	8,635	10,717	12,656	14,830	16,950	21,199	22,780	22,252	234
Woodville	11,381	13,408	17,123	19,548	21,866	25,016	29,124	33,702	30,484	168
EPPI	7,301	9,176	10,583	10,060	10,162	a	--	--	--	-100
ESS & H	5,500	6,784	8,567	9,719	11,372	11,775	14,466	15,378	16,774	205
Western R. C.	1,159	1,711	2,230	2,599	2,950	3,381	4,225	247	a	-100
South Mt. R. C.	5,410	7,529	9,920	13,020	15,878	18,296	21,326	21,145	20,728	283
Total	175,559	220,202	269,756	305,551	342,400	370,622	446,643	453,916	442,542	152

a. State mental hospital closed or converted to other use.

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years.

The range of <u>increases</u> in funds provided varies from 66 percent for Philadelphia to 365 for Clarks Summit. Aside from Philadelphia, facilities with relatively low rates of increase in funding are: Harrisburg, 139 percent and Torrance, 143 percent.

Facilities with the highest rates of growth in funds provided are: Clarks Summit, 365 percent; Somerset, 296 percent; Mayview, 290 percent; and Haverford, 287 percent.

Table 5 shows the number of patients residing in each mental health facility at two-year intervals over the 1970-87 time period and the percentage decrease in patient population over the period. Hospitals recording the largest percentage decreases in population, other than those which were closed or converted to other uses, are Philadelphia, 80 percent; Torrance, 76 percent; Farview, 74 percent; Warren, 73 percent; and Danville, 73 percent.

Facilities with the smallest decrease in patient population are Eastern State School and Hospital, 4 percent; Haverford, 25 percent; South Mountain Restoration Center, 42 percent; Somerset, 43 percent; and Clarks Summit, 46 percent.

Table 6 shows the statewide staff levels by discipline for each State mental hospital as of May 30, 1986. The staffing data indicate that of the total staff serving the State mental hospital system, nearly one-third are nonclinical workers and about two-thirds are on the clinical staff.

Table 5

PATIENTS RESIDING IN STATE MENTAL HOSPITALS AND RESTORATION CENTERS, BY FACILITY, AT TWO-YEAR INTERVALS 1970 THROUGH 1986 AND 1987[a]

Facility	1970	1972	1974	1976	1978	1980	1982	1984	1986	1987	Percentage decrease 1970-87
Allentown	1,205	1,110	923	676	556	511	484	460	422	455	62%
Clarks Summit	893	757	592	509	585	576	624	580	466	481	46
Danville	1,787	1,500	1,289	942	771	784	841	698	527	489	73
Dixmont	545	460	458	376	354	339	274	b	--	--	100
Embreeville	685	290	235	216	84	b	--	--	--	--	100
Farview	768	486	461	294	218	222	205	226	184	198	74
Harrisburg	1,478	1,238	841	606	491	502	471	454	449	469	68
Haverford	561	566	469	425	397	435	381	411	423	419	25
Hollidaysburg	611	494	379	c	b	--	--	--	--	--	100
Mayview	2,293	1,900	1,713	1,503	1,310	1,221	1,074	913	695	712	69
Norristown	2,113	1,736	1,535	1,356	1,239	1,244	1,257	1,076	966	893	58
Philadelphia	2,725	1,838	1,295	1,047	940	903	776	661	575	537	80
Retreat	681	659	606	435	272	b	--	--	--	--	100
Somerset	453	347	231	412	366	360	316	295	292	257	43
Torrance	1,912	1,586	1,316	1,074	749	662	654	597	441	461	76
Warren	2,014	1,328	1,018	770	772	847	824	770	552	554	73
Wernersville	1,177	974	832	681	610	543	585	577	490	530	55
Woodville	2,015	1,661	1,258	1,009	787	782	687	727	565	558	72
EPPI	96	95	86	84	78	74	b	--	--	--	100
ESS & H	175	203	185	218	155	125	161	171	143	168	4
Western R.C.	93	97	90	94	93	88	90	b	--	--	100
South Mt. R.C.	964	869	787	842	807	783	761	782	633	562	42
Total	25,244	20,194	16,599	13,569	11,634	11,001	10,465	9,398	7,823	7,743	69

a. Patient count is as of October each year except in 1986 and 1987 when the count is for July.
b. State mental hospital closed or converted to other use.
c. No actual patient population available in Governor's Budget for the years 1976 through 1978.

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years and the office of mental health.

Table 6

TOTAL NUMBER OF STAFF IN STATE MENTAL HOSPITALS AND SOUTH MOUNTAIN RESTORATION CENTER BY DISCIPLINE AND FACILITY AS OF MAY 30, 1986

Facility	Psychiatrist	Physician	Psychologist	Social worker	Nurse	Rehab. therapist	MH Professional	MH worker	Health professional	Admin. professional	Clerical/ secretarial	Facility support	Total
Allentown	11	10	5	12	151	37	1	142	13	21	63	159	625
Clarks Summit	9	8	7	10	178	47	3	174	8	27	39	164	674
Danville	9	9	5	18	204	40	—	289	12	28	42	207	863
Eastern State	10	4	5	6	56	16	1	137	4	21	28	149	437
Farview	3	6	1	7	71	17	1	269	6	24	31	104	540
Harrisburg	10	15	7	12	151	51	1	189	13	31	34	182	696
Haverford	22	14	8	12	93	35	—	171	13	25	44	126	563
Mayview	10	19	16	25	216	69	—	515	25	34	70	267	1,266
Norristown	37	32	13	34	216	77	1	454	23	62	78	359	1,386
Philadelphia	20	24	17	7	170	59	1	340	19	34	67	213	971
Somerset	4	10	4	7	111	26	1	71	8	23	21	103	389
South Mountain	—	6	—	1	141	—	—	—	270	22	42	230	712
Torrance	6	11	3	15	173	39	—	203	25	27	42	204	748
Warren	13	6	7	9	247	59	1	183	21	29	49	228	852
Wernersville	8	11	8	13	225	38	1	92	11	25	43	197	672
Woodville	10	19	8	15	198	53	1	215	15	29	52	259	874
Total	182	204	114	203	2,601	663	13	3,444	486	462	745	3,151	12,268

SOURCE: Pennsylvania Department of Public Welfare, Office of Mental Health, Bureau of Mental Health Program Management.

Admissions to and Patient Census in State Mental Hospitals

Table 7 presents the number and percent distribution by legal status of admissions to State mental hospitals from 1980 to date. Total projected admissions for 1987 are 7,470 if the admissions rates for the first six months continue over the remainder of 1987. The projected total number of admissions for 1987 marks a breakout from the 6,530 to 6,850 admissions range which prevailed during the first seven years of the 1980s.

The admissions record over the past 7 1/2 years is characterized by a marked reduction in the number of voluntary civil admissions and a corresponding increase in the number of involuntary civil and criminal admissions. In 1987, involuntary admissions constitute 90.4 percent of all admissions to State mental hospitals. Part of the explanation for the rise in involuntary admissions is the growth in the inmate population in Pennsylvania.[4] The distinction between voluntary and involuntary admissions may not always be meaningful. It is contended that there is a tendency when overall admissions are restricted for persons wishing treatment to attempt to meet the criteria for involuntary treatment.

Table 8 shows admissions to and the census count in Pennsylvania's State mental hospitals (excluding restoration centers which reported no admissions during this period) by region for the

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[4]Pennsylvania Department of Corrections, Division of Planning, Research and Statistics, Annual Statistical Report, 1980-86. The inmate population in Pennsylvania prisons has increased by 85 percent over the 1980-86 time period.

Table 7

ADMISSIONS TO PENNSYLVANIA STATE MENTAL HOSPITALS AND THE PERCENT DISTRIBUTION OF ADMISSIONS BY LEGAL STATUS, 1980-87

Year	Total admissions	Voluntary civil	Involuntary civil	Involuntary criminal	Un-classified
1980	6,824	1,934	3,836	849	205
Percent of total	**100.0%**	**28.3**	**56.2**	**12.4**	**3.0**
1981	6,539	1,484	4,007	924	124
Percent of total	**100.0%**	**22.7**	**61.3**	**14.1**	**1.9**
1982	6,571	1,389	3,963	870	349
Percent of total	**100.0%**	**21.1**	**60.3**	**13.2**	**5.3**
1983	6,535	1,089	4,402	965	79
Percent of total	**100.0%**	**16.7**	**67.4**	**14.8**	**1.2**
1984	6,619	828	4,606	1,098	87
Percent of total	**100.0%**	**12.5**	**69.6**	**16.6**	**1.3**
1985	6,728	665	4,671	1,291	101
Percent of total	**100.0%**	**9.9**	**69.4**	**19.2**	**1.5**
1986	6,855	574	4,847	1,333	101
Percent of total	**100.0%**	**8.4**	**70.7**	**19.4**	**1.5**
*1987 (Projected)	7,470	650	5,472	1,274	74
Percent of total	**100.0%**	**8.7**	**73.3**	**17.1**	**1.0**

SOURCE: Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health, Weekly and Semi-monthly Admission/Discharge Report for State-owned Mental Health Facilities, 1981-87.

*Projected admissions based on first six months of admissions in 1987. Total admissions for the first six months of 1987 were 3,735. A similar projection is made for the categories of admissions.

Table 8

ADMISSIONS TO AND PATIENT CENSUS COUNT IN
STATE MENTAL HOSPITALS
BY REGION, 1980-87

Year	Total	South-east	North-east	Central	Western
1980 Admissions	6,824	2,222	1,585	1,167	1,850
Census count	10,130	2,781	1,852	1,646	3,851
1981 Admissions	6,539	1,832	1,731	1,117	1,859
Census count	9,813	2,581	1,925	1,705	3,602
1982 Admissions	6,571	1,597	1,817	1,002	2,155
Census count	9,614	2,575	1,898	1,628	3,513
1983 Admissions	6,535	1,645	1,929	959	2,002
Census count	8,925	2,417	1,893	1,568	3,047
1984 Admissions	6,619	1,714	1,864	959	2,082
Census count	8,255	2,272	1,772	1,385	2,826
1985 Admissions	6,728	1,753	1,874	984	2,117
Census count	7,622	2,190	1,685	1,317	2,430
1986 Admissions	6,855	1,867	2,070	876	2,042
Census count	7,190	2,107	1,562	1,268	2,253
1987 Admissions (*projected)	7,470	2,010	2,374	994	2,092
Census count	7,181	2,017	1,664	1,215	2,285

SOURCE: Commonwealth of Pennsylvania, Department of Welfare, Office of Mental Health, Weekly and Semi-weekly Admission/Discharge Report for State-owned Facilities, 1980-87. Commonwealth of Pennsylvania, Governor's Executive Budget, various years and the Office of Mental Health. The census count for the years 1980-84 is in October, while the census count for the 1985-87 years is for July.

*Projected admissions based on the first six months of admissions in 1987.

1980 to the 1987 time period. Assuming that admissions continue at the same pace as that exhibited in the first six months of 1987, admissions in the Southeast region will reach 2,010; in the Northeast region, 2,374; in the Central region, 994; and in the Western region, 2,092. The percentage rates of increase in projected admissions for 1987 over the average level of admissions for the 1980-86 period for each region are as follows: Southeast, 11.4 percent; Northeast, 29.1 percent; Central, -1.5 percent; and Western, 3.8 percent. The 1987 statewide increase in projected admissions over the 1986 total is not reflected in the patient census which was 9 less in July 1987 (7,181) than in July 1986 (7,190). However, the rate of decline in the patient census slowed significantly between 1986 and 1987 when compared to an annual average drop of about 490 patients over the 1980-86 period.

The regional relationship between changes in admissions and changes in the patient census is diverse. While projected admissions are greater in every region in 1987 than 1986 admissions, the 1987 patient census count is larger than 1986 only in the Northeast and Western regions.

For the State mental hospital system as a whole and for any region, an increase in admissions is compatible with a falling patient census if the average length of stay decreases (i.e., patient turnover increases). If admissions increase in the future at the rate recorded between 1986 and 1987 it is unlikely that the patient population will

continue to decline. Over the 1980-86 time period, an approximately steady annual number of admissions was compatible with a substantial decline of 2,940 patients in the patient population in the State mental hospitals.

COMMUNITY MENTAL HEALTH SERVICE SYSTEM

The Mental Health and Mental Retardation Act of 1966 requires county governments to provide community mental health services at the community level. Administration and direction of these services are provided by 44 county administrative units (CAUs); some are single county units and others are multi-county units. Each CAUs is assisted by a 13-member advisory board appointed by the county commissioners. Services are usually delivered by private facilities under contract and under the direction of the county administrative unit. In 1986, there were over 1,000 licensed facilities under contract to provide services to the community mental health service system. The Office of Community Programs in the Department of Public Welfare has oversight responsibilities with respect to the management and service delivery of the 44 community-administered programs. Moreover, the department's Office of Community Programs licenses the private suppliers of services to the various community mental health programs.

In fiscal year 1984-85, the various services provided and the quantities of each type of service were as follows:[5]

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[5]Pennsylvania Department of Welfare, Office of Mental Health, 1986-89 Mental Health Plan and 1985-86 Annual Report, Volume 1, pp. 2-4.

-- Inpatient treatment--short-term psychiatric hospitalization in psychiatric units of general hospitals and private psychiatric hospitals - 294,813 days.

-- Outpatient services--clinicial services provided to residents in the community - 1,317,475 hours.

-- Partial hospitalization--intensive day care treatment programs designed as an alternative to inpatient care - 7,574,903 hours.

-- Social rehabilitation--services that help former State hospitals and aftercare clients to participate in community life without supervision - 1,938,170 hours.

-- Vocational rehabilitation--services to develop and improve work skills of clients to facilitate entry into the work force - 1,842,718 hours.

-- Emergency/crisis intervention--services to individuals facing psychiatric crises situations - 288,566 hours.

-- Residential arrangements--supervised residential living arrangements consisting of group homes and apartments for persons with chronic mental illness and former mental hospital patients - 856,564 days.

-- Case management--direct staff services to clients, providing planning and coordination of comprehensive treatment from initial intake to case closing - 376,958 hours.

Funding for the community mental health program is provided from a variety of sources: State and federal appropriations, county

matching funds and other revenues collected by the service providers. Table 9 presents the amounts and sources of funds for the four fiscal years from 1981-82 to 1985-86. A complete accounting of total funds available to community mental health programs is not available for years prior to 1982 fiscal year when community mental health and mental retardation services were administered under one budget.

County programs are required by law to exhaust all nonstate sources of funds before applying State funds[6] and counties are required by law to contribute 10 percent of the costs of services other than inpatient and partial hospitalization.[7] County funds and other revenues accounted for about 60 percent of the total funds available to the county programs in fiscal 1985-86.

Total funds provided to the community programs grew by 47 percent over the four-year period 1981-82 through 1985-86, an average of 11.75 percent annually. Federal funds in 1985-86 consisted of a social service block grant and an alcohol, drug abuse and mental health block grant totaling $26.4 million. Beginning in fiscal 1983-84, federal funds were allocated to county administrative units with no previous federal funding history and to other units on the basis of need.[8]

State funds amounted to almost $108 million in the 1985-86 fiscal year. State funds are provided to the various county

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[6]Ibid., pp. 2-5.
[7]Ibid., pp. 2-4.
[8]Ibid., pp. 3-4.

Table 9

STATE, FEDERAL, COUNTY AND OTHER FUNDS PROVIDED
TO THE COMMUNITY MENTAL HEALTH PROGRAM
FISCAL YEARS 1981-82 THROUGH 1985-86
(Dollars in 000's)

Fiscal year	Source of funds				
	State	Federal	County	Other*	Total
1981-82	$84,832	$10,113	$7,922	$127,982	$230,849
1982-83	91,216	16,901	9,050	132,042	249,209
1983-84	95,650	23,167	10,022	146,393	275,232
1984-85	98,254	25,665	11,711	181,760	317,390
1985-86	107,637	26,397	13,977	191,111	339,122

*The approximate breakdown of other revenues in the 1984-85 fiscal year is: medical assistance payments - $101 million, private insurance payments - $48 million, program fees - $10 million and other funds - $23 million. The revenues reported are lower than actual revenues collected because private fee for services agencies are not required to report revenues from all services, but they are required to maintain an account of all revenues for audit purposes.

SOURCE: Pa. Department of Public Welfare, Office of Mental Health, 1986-89 Mental Health Plan and 1985-86 Annual Report Volume 1, pages 3-2/3-3. Data for fiscal 1985-86 revenues were supplied by the department's Office of Mental Health.

administrative units based on a structured-ranking process using criteria related to the distribution of dollars, service system balance, revenue generation, unit costs and other standards designed to assess the efficiency of the county programs. In addition, State funds are provided for system expansion on the basis of needs factors such as poverty level and the number of discharged State mental hospital patients referred to the various community programs.[9]

Table 10 presents data on persons served, admissions and cases closed in the community mental health program. In the 1973-74 through 1975-76 fiscal years, "persons provided services" consisted of an unduplicated count of persons served. Beginning in 1976-77, the data represent a count of persons served or admitted and cases closed. The high count of persons served in the 1980-81 and 1981-82 fiscal years is explained by the inclusion of a large number of clients treated in private mental health facilities.

In 1985-86, more than 221,000 persons received services in the community programs. This count includes those who entered the program in a prior year and remained, first admissions and readmissions from a prior year. About 40,000 of the 221,000 persons receiving services are chronically mentally ill and many of them have a history of treatment in a State mental hospital. Reportedly, about 73 percent of all clients admitted to the community programs are first admissions.[10] Applying this percentage to the admissions total of

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[9]Ibid., pp. 3-6.
[10]Ibid., pp. 3-85.

Table 10

PERSONS PROVIDED MENTAL HEALTH SERVICES,
ADMISSIONS AND CASES CLOSED
COMMUNITY MENTAL HEALTH PROGRAMS
FISCAL YEARS 1973-74 THROUGH 1985-86

Fiscal year	Persons provided services in community program	Total admissions to community program	Cases closed in community program
1973-74	108,659	na	na
1974-75	158,500	na	na
1975-76	168,000	na	na
1976-77	211,099	na	na
1977-78	209,600	100,357	90,712
1978-79	223,714	94,473	88,715
1979-80	241,779	97,297	103,022
1980-81	315,772	94,228	81,036
1981-82	334,735	94,228	81,037
1982-83	242,457*	83,620*	104,584*
1983-84	211,699	85,874	77,038
1984-85	223,406	89,134	88,897
1985-86	221,017	87,623	81,792

*The reduction in the number of persons provided services and admissions in 1982-83 fiscal year from the previous years according to the Governor's Executive Budget, 1984-85, pp. 604-605 is due to exclusion of private mental health clients in the county reporting data. The increase in cases closed is due to removal of inactive cases from the county records.

SOURCE: Commonwealth of Pennsylvania, Governor's Executive Budget, various years and Pa. Department of Welfare, Office of Mental Health.

87,623 patients in 1985-86, yields estimates of about 64,000 new admissions and 23,600 readmissions.

Table 11 covers the statewide community program staffing levels for 1984, based on a special one-year survey conducted by the Office of Mental Health of all the private providers of contracted services with the county administrative units. There are no historical data on community program staff levels. Clinical positions comprise 63 percent of all staff positions and about 38 percent of the clinical staff have master's degrees or higher qualifications.

Table 12 presents data on the community mental health expenditures by services rendered and by source of funds and units of service rendered and expenditures per unit of service rendered for the 1984-85 fiscal year. Units of service rendered measure client hours or days or face-to-face contact hours where indicated.

Administrative office and community services spent about $14 million in 1984-85, or 4.4 percent of the total expenditures of the community system. The community service unit conducts educational and prevention programs for the community mental health system.

Case management expenditures were $28.2 million or about 8.9 percent of total expenditures, with about $23 million obtained from State and federal appropriations. Case management services totaled 376,958 hours. These hours represent actual face-to-face contact hours with clients in the community mental health system. Case management expenditures amounted to $74.80 per client contact hour.

Table 11

CLINICAL, ADMINISTRATIVE AND VACANT
FULL-TIME EQUIVALENT POSITIONS BY DISCIPLINE,
COMMUNITY MENTAL HEALTH PROGRAMS
1984

Discipline	Clinical positions	Adminis-trative positions	Vacant positions	Total positions	Percentage of total positions vacant
Board certified psychiatrists	149	14	11	174	6.3%
Other psychiatrists	112	7	10	129	7.8
Other physicians	11	1	0	12	.0
Doctorate psychologists	140	35	9	184	4.9
Master's psychologists	255	45	22	322	6.8
Doctorate or master's social workers	476	102	22	600	3.7
Registered nurses master's or above	36	7	1	44	2.3
Registered nurses less than master's	195	17	3	215	1.4
Licensed practical nurses	24	1	1	26	3.9
Rehabilitation therapists master's or above	92	12	13	117	11.1
Other MH professionals master's or above	580	104	34	718	4.7
Mental health workers bachelor's level	1,357	111	61	1,529	4.0
Mental health workers associate level	156	11	9	176	5.1
Mental health workers	475	34	21	530	3.9
Health professionals and assistants	17	2	0	19	0
Administrative professionals bachelors or above	18	252	4	274	1.5
Clerical/secretarial support staff	9	1,235	24	1,268	1.9
Facility support staff	13	172	3	188	1.6
Total	4,115	2,162	248	6,525	3.8

SOURCE: Pa. Department of Public Welfare, Office of Mental Health, "1984 Community Mental Health Manpower Survey."

Table 12

COMMUNITY MENTAL HEALTH EXPENDITURES BY SERVICES
RENDERED AND BY SOURCE OF FUNDS, SERVICE UNITS
RENDERED AND EXPENDITURES PER UNIT OF SERVICES RENDERED, 1984-85

	SOURCES OF REVENUE (DOLLARS IN 000'S)									
Service rendered	State	County	Federal	Medical assistance	Private in-surance	Program fees	Other	Totals	Units of service rendered	Expend-itures per unit of service rendered
Administrative office	$6,505	$894	$111	$0	$0	$29	$1,629	$9,168	--	--
Community service	3,146	351	321	8	12	207	751	4,796	--	--
Case manage-ment	15,068	1,787	7,887	479	103	515	2,357	28,196	376,958 hours	$74.80 per hour
Outpatient	24,172	2,794	5,562	10,894	4,633	4,920	6,629	59,603	1,317,475 hours	45.24 per hour
Inpatient	6,752	83	0	59,905	40,673	2,872	940	111,225	294,813 days	377.27 per day
Partial hospit-alization	8,023	16	254	29,072	2,259	751	4,057	44,433	7,574,903 hours	5.87 per hour
Emergency service	11,549	1,398	1,095	328	127	198	1,229	15,925	288,566 hours	55.19 per hour
Vocational reh-abilitation	2,972	337	3,048	7	6	59	1,173	7,601	1,842,718 hours	4.12 per hour
Social reh-abilitation	6,870	1,138	1,280	58	9	236	894	10,485	1,938,170 hours	5.41 per hour
Residential arrangements	13,196	2,915	6,106	0	184	327	3,228	25,956	856,564 days	30.30 per day
Totals	98,254	11,711	25,665	100,751	48,007	10,115	22,887	317,390	--	--

NOTE: Items may not add to totals because of rounding.

SOURCE: Pa. Department of Welfare, Office of Mental Health, Pennsylvania 1986-89 Mental Health Plan and 1985-86 Annual Report, Volume I, 1987, pp. 2-4 and 3-97.

Inpatient days cost $111.2 million in fiscal 1984-85. This is 35 percent of the total expenditures on the community mental health system. Medical assistance and private insurance payments provided over $100 million to inpatient services. In fiscal 1984-85, inpatient care cost $377.27 per day.

Emergency services/crisis intervention supplied 288,566 face-to-face actual contact hours of service to individuals in crisis situations at a total outlay of $15.9 million or $55.19 per crisis contact hour.

Residential arrangements or community residential rehabilitation are supervised group homes or apartments for chronically mentally ill patients. The cost of services provided was almost $26 million in fiscal 1984-85 and most of the money is from State, local and federal sources. In fiscal 1984-85, 856,564 client days of rehabilitation services were rendered at the cost of $30.30 per day. Client incomes help to offset the food and housing cost incurred in community residential rehabilitation.

IV. An Interstate Comparison of Public Mental Health Operations

Expenditures for public mental health services in the United States in fiscal year 1985 totaled $9.8 billion: $5.4 billion for state mental hospitals, $4.1 billion for community-based mental health services and $309 million for support activities.

Table 13 shows, by state, total public mental health expenditures, per capita expenditures and the ranking of states by per capita expenditures. The last column of the table contains a ranking of the states by the quality of state mental health programs as assigned by Torrey and Wolfe.[11] Expenditures on Pennsylvania's public mental health programs in 1985 totalled about $804 million, ranking the Commonwealth third in total expenditures behind New York with $2.3 billion and California with $894 million. On a per capita basis, Pennsylvania ranks second in the nation with per capita expenditures of $67.89 which is 63 percent above the national average of $41.62. The top five states in expenditures per capita are New York, Pennsylvania, Vermont, Minnesota and New Hampshire. The five states

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[11]E. F. Torrey, M.D. and S. M. Wolfe, M.D., Care of the Seriously Mentally Ill, A Rating of State Programs (Washington, D.C.: Public Citizen Health Research Group, 1986). For a summary of the methodology used in this study, see reference note at page 61.

Table 13

TOTAL MENTAL HEALTH EXPENDITURES, EXPENDITURES PER CAPITA, PER CAPITA RANK AND RANK BY TORREY AND WOLFE STATE RATING, FISCAL YEAR 1985

State	Total Mental Health Expenditures[1] (000's)	Expenditures per capita	Per capita expend-itures rank	Rank by Torrey and Wolfe rating
Alabama	$111,015	$27.78	32	29
Alaska	22,334	44.85	9	28
Arizona	45,902	14.52	50	33
Arkansas	62,462	26.60	36	14
California	893,503	34.28	21	42
Colorado	101,602	31.88	24	3
Connecticut	139,101	44.02	12	12
Delaware	28,415	46.05	8	47
Florida	287,514	25.52	39	16
Georgia	163,412	27.67	34	21
Hawaii	22,612	22.66	45	50
Idaho	14,971	14.99	49	30
Illinois	335,126	29.16	28	40
Indiana	211,637	38.54	17	32
Iowa	68,177	23.66	44	6
Kansas	104,951	43.30	14	11
Kentucky	70,090	18.99	47	8
Louisiana	113,994	25.62	38	31
Maine	51,156	44.29	10	4
Maryland	191,602	44.12	11	17
Massachusetts	267,834	46.11	7	41
Michigan	444,621	48.98	6	36
Minnesota	253,753	60.55	4	37
Mississippi	61,652	23.78	43	48
Missouri	138,924	27.72	33	22
Montana	27,318	33.23	22	45
Nebraska	44,352	27.84	30	9
Nevada	24,004	25.95	37	25
New Hampshire	50,739	51.10	5	7
New Jersey	330,010	43.77	13	27
New Mexico	35,256	24.60	41	49
New York	2,250,401	126.74	1	26
North Carolina	232,308	37.81	18	19
North Dakota	24,396	36.25	20	35
Ohio	431,600	40.22	16	23
Oklahoma	100,903	30.89	25	34
Oregon	66,865	24.89	40	5
PENNSYLVANIA	803,771	67.89	2	24
Rhode Island	39,053	40.60	15	2
South Carolina	107,362	32.61	23	44
South Dakota	15,251	21.73	46	20
Tennessee	133,582	28.18	29	18
Texas	305,059	18.80	48	46
Utah	45,087	27.53	35	13
Vermont	35,560	66.47	3	15
Virginia	205,343	37.03	19	38
Washington	128,373	29.50	27	10
West Virginia	47,371	24.47	42	43
Wisconsin	132,830	27.82	31	1
Wyoming	15,412	30.52	26	39
United States	9,838,566	41.62	--	--

[1]Expenditures include funds from all sources; federal, state, local governments, Medicaid and Medicare, First and Third Party Payments and miscellaneous funds.

SOURCES: National Association of State Mental Health Program Directors, Funding Sources and Expenditures of State Mental Health Agencies: Revenue Expenditure Study Results, Fiscal Year 1985 (Alexandria, Va., 1987) and E. F. Torrey, M.D. and S. M. Wolfe, M.D., Care of the Seriously Mentally Ill: A Rating of State Programs (Washington, D.C., 1986).

with the lowest expenditures per capita are Arizona, Idaho, Texas, Kentucky and South Dakota.

Inspection of the data in table 13 shows that little or no correlation exists between the quality of state programs as measured by Torrey and Wolfe and per capita expenditures. Wisconsin, which ranks 31st in expenditures per capita, is given the highest quality ranking by Torrey and Wolfe. They rank Delaware 47th, while it ranks eighth in per capita expenditures. Only one state of the top five states in the Torrey and Wolfe ranking is among the top ten in the ranking of states by expenditure per capita. More surprisingly, only two of the ten states ranked highest by Torrey and Wolfe spent more than the national average of $41.62 per capita in 1985.

Table 14 contains a breakdown, by state, of total public mental health expenditures into expenditures for the major programs: state mental hospitals, community-based programs and support services.

In the nation as a whole, expenditures are distributed as follows: 55 percent on state mental hospitals, 42 percent on community-based programs and 3 percent on support activities. Pennsylvania resembles the United States distribution with 58 percent on the state mental hospitals, 40 percent on the community-based programs and 2 percent on support activities. Vermont expends the smallest percentage of total funds--24 percent--on state mental hospitals. Delaware, on the other hand, devotes 86 percent of total expenditures to state mental hospitals. Of all the states, 40

Table 14

TOTAL PUBLIC MENTAL HEALTH EXPENDITURES
BY MAJOR PROGRAM, BY STATE, FISCAL YEAR 1985

	Total mental health expenditures (000's)	State mental hospital expend- itures (000's)	Per- cent of total	Comm- unity based expend- itures (000's)	Per- cent of total	Supp- ort act- itivies (000's)	Per- cent of total
Alabama	$111,015	$87,663	79%	$20,836	19%	$2,516	2%
Alaska	22,334	13,813	62	7,240	32	1,282	6
Arizona	45,902	23,323	51	21,464	47	1,115	2
Arkansas	62,462	32,336	52	25,450	41	4,676	7
California	893,503	257,059	29	607,543	68	28,901	3
Colorado	101,602	56,057	55	44,236	44	1,309	1
Connecticut	139,101	98,283	71	31,161	22	9,656	7
Delaware	28,415	24,527	86	3,518	12	370	1
Florida	287,514	156,424	54	131,090	46	—	0
Georgia	163,412	103,120	63	58,303	36	1,990	1
Hawaii	22,612	8,698	38	12,371	55	1,543	7
Idaho	14,971	8,751	58	5,691	38	529	4
Illinois	335,126	180,656	54	140,996	42	13,475	4
Indiana	211,637	89,564	42	120,280	57	1,793	1
Iowa	68,177	28,002	41	39,862	58	313	1
Kansas	104,951	53,632	51	49,226	47	2,093	2
Kentucky	70,090	45,772	65	22,469	32	1,849	3
Louisiana	113,994	77,743	68	31,766	28	4,485	4
Maine	51,156	28,751	56	21,263	42	1,141	2
Maryland	191,602	144,124	75	40,605	21	6,873	4
Massachusetts	267,834	91,185	34	143,127	53	33,522	13
Michigan	444,621	281,111	63	145,948	33	17,561	4
Minnesota	253,753	152,126	60	101,161	40	466	0
Mississippi	61,652	45,822	74	14,581	24	1,249	2
Missouri	138,924	74,929	54	59,065	43	4,931	4
Montana	27,318	16,707	61	10,328	38	283	1
Nebraska	44,352	28,220	64	15,016	34	1,115	3
Nevada	24,004	15,086	63	8,534	36	384	2
New Hampshire	50,739	25,780	51	23,614	47	1,346	3
New Jersey	330,010	230,921	70	91,722	28	7,366	2
New Mexico	35,256	21,001	60	13,912	39	343	1
New York	2,250,401	1,322,148	59	855,154	38	73,099	3
North Carolina	232,308	145,751	63	84,400	36	2,156	1
North Dakota	24,396	15,472	63	8,747	36	176	1
Ohio	431,600	202,699	47	215,645	50	13,256	3
Oklahoma	100,903	64,042	63	32,482	32	4,378	4
Oregon	66,865	40,587	61	23,682	35	2,596	4
PENNSYLVANIA	803,771	469,526	58	317,371	40	16,874	2
Rhode Island	39,053	21,651	55	16,741	43	661	2
South Carolina	107,362	79,909	74	21,336	20	6,116	6
South Dakota	15,251	11,210	74	3,673	24	368	2
Tennessee	133,582	78,007	58	51,698	39	3,877	3
Texas	305,059	193,399	63	95,610	31	16,051	5
Utah	45,087	13,854	31	30,433	67	799	2
Vermont	35,560	8,674	24	25,964	73	922	3
Virginia	205,343	137,696	67	59,251	29	8,396	4
Washington	128,373	61,303	48	64,794	50	2,276	2
West Virginia	47,371	27,706	58	19,139	40	526	1
Wisconsin	132,830	40,324	30	91,054	69	1,451	1
Wyoming	15,412	11,232	73	3,587	23	594	4
United States	9,838,566	5,446,376	55	4,083,139	42	309,047	3

1. Note: expenditures include funds from all sources; federal, state local government, medicaid and medicare, first and third party payments and miscellaneous funds.

SOURCE: National Association of State Mental Health Program Directors, Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year 1985 (Alexandria, Virginia 1987).

Note: Because of rounding, detail may not sum to total.

dedicate over 50 percent of their total funds to state mental hospitals.

Table 15 pertains only to state mental hospitals and shows, by state, total expenditures, resident patients, expenditures per patient and a state ranking by expenditures per patient. Annual expenditures per patient range from $26,612 in Georgia to $145,004 in Arkansas; the national average is $47,586. Pennsylvania ranks 12th with per patient expenditures of $54,495--15 percent above the national average. The top five states in expenditures per patient are: Arkansas, Nevada, New Hampshire, Minnesota and Alaska. Typically, as may be seen in table 4, states with high mental hospital expenditures per patient tend to have a relatively small patient population. For example, Arkansas, Nevada and New Hampshire rank 50th, 49th and 40th, respectively, in number of public mental hospital patients per 100,000 total civilian population.

It is helpful in analyzing the comparative cost of maintaining and operating a state mental hospital system to consider expenditures per capita as the product of expenditures per patient and the number of patients per capita. The relative variation in these two ratios provides a convenient measure of the potential degree of policy control over total costs of state mental hospitals.

In table 16, for convenience of presentation, the resident patient rate is expressed as the annual average number of patients per 100,000 civilian population. The number of patients in the nation is 48 per 100,000 population. Pennsylvania's count is 73 per 100,000

Table 15

STATE MENTAL HOSPITAL EXPENDITURES, RESIDENT PATIENTS, EXPENDITURES PER PATIENT AND STATE RANK, 1985 FISCAL YEAR

State	State mental hospital expenditures (000's)	Resident patients[1]	Expenditures per patient	Rank by expend-itures per patient
Alabama	$87,663	1,987	$44,118	25
Alaska	13,813	204	67,711	5
Arizona	23,323	571	40,846	36
Arkansas	32,336	223	145,004	1
California	257,059	5,326	48,265	17
Colorado	56,057	926	60,537	8
Connecticut	98,283	2,390	41,123	34
Delaware	24,527	534	45,931	22
Florida	156,424	3,823	40,917	35
Georgia	103,120	3,875	26,612	50
Hawaii	8,698	241	36,091	40
Idaho	8,751	188	46,548	20
Illinois	180,656	4,141	43,626	27
Indiana	89,564	2,605	34,382	43
Iowa	28,002	919	30,470	46
Kansas	53,632	1,357	39,522	37
Kentucky	45,772	798	57,358	10
Louisiana	77,743	1,781	43,651	26
Maine	28,751	598	48,079	18
Maryland	144,124	2,724	52,909	13
Massachusetts	91,185	2,546	35,815	41
Michigan	281,111	4,268	65,865	6
Minnesota	152,126	1,863	81,656	4
Mississippi	45,822	1,518	30,186	47
Missouri	74,929	2,255	33,228	44
Montana	16,707	335	49,872	16
Nebraska	28,220	649	43,482	28
Nevada	15,086	115	131,183	2
New Hampshire	25,780	264	97,652	3
New Jersey	230,921	5,600	41,236	32
New Mexico	21,001	413	50,850	15
New York	1,322,148	23,109	57,214	11
North Carolina	145,751	3,037	47,992	19
North Dakota	15,472	516	29,984	48
Ohio	202,699	4,409	45,974	21
Oklahoma	64,042	1,239	51,688	14
Oregon	40,587	976	41,585	31
PENNSYLVANIA	469,526	8,616	54,495	12
Rhode Island	21,651	371	58,358	9
South Carolina	79,909	2,411	33,144	45
South Dakota	11,210	417	26,882	49
Tennessee	78,007	1,896	41,143	33
Texas	193,399	5,017	38,549	39
Utah	13,854	307	45,127	23
Vermont	8,674	140	61,957	7
Virginia	137,696	3,566	38,614	38
Washington	61,303	1,414	43,354	29
West Virginia	27,706	795	34,850	42
Wisconsin	40,324	912	44,215	24
Wyoming	11,232	268	41,910	30
United States	$5,446,376	114,453	$47,586	—

[1]Resident patients as of December 31, 1984.

SOURCE: National Association of State Mental Health Program Directors, Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year 1985 (Alexandria, Virginia, 1987) and National Institute of Mental Health, Survey and Reports Branch, Additions and Resident Patients at End of Year, State and County Mental Hospitals, by State, United States, 1984 (Rockville, Maryland, 1987).

Table 16

RESIDENT PATIENTS, RESIDENT PATIENTS PER 100,000 CIVILIAN POPULATION AND STATE RANK, 1984

State	Resident patients	Resident patients per 100,000 civilian population	Rank by resident patients per 100,000 civilian population
Alabama	1,987	50	16
Alaska	204	41	25
Arizona	571	18	48
Arkansas	223	9	50
California	5,326	20	44
Colorado	926	29	38
Connecticut	2,390	76	4
Delaware	534	87	2
Florida	3,823	34	34
Georgia	3,875	66	8
Hawaii	241	24	42
Idaho	188	19	46
Illinois	4,141	36	33
Indiana	2,605	47	18
Iowa	919	32	36
Kansas	1,357	56	13
Kentucky	798	22	43
Louisiana	1,781	40	28
Maine	598	52	15
Maryland	2,724	63	10
Massachusetts	2,546	44	22
Michigan	4,268	47	18
Minnesota	1,863	44	21
Mississippi	1,518	59	12
Missouri	2,255	45	20
Montana	335	41	26
Nebraska	649	41	27
Nevada	115	12	49
New Hampshire	264	27	40
New Jersey	5,600	74	5
New Mexico	413	29	39
New York	23,109	130	1
North Carolina	3,037	49	17
North Dakota	516	77	3
Ohio	4,409	41	23
Oklahoma	1,239	38	31
Oregon	976	36	32
PENNSYLVANIA	8,616	73	7
Rhode Island	371	39	30
South Carolina	2,411	73	6
South Dakota	417	59	11
Tennessee	1,896	40	29
Texas	5,017	31	37
Utah	307	19	47
Vermont	140	26	41
Virginia	3,566	64	9
Washington	1,414	33	35
West Virginia	795	41	24
Wisconsin	912	19	45
Wyoming	268	53	14
United States	114,453	48	—

SOURCE: National Institute of Mental Health, Survey and Reports Branch, Additions and Resident Patients at End of Year, State and County Mental Hospitals, by State, United States, 1984 (Rockville, Maryland, 1987).

population, the seventh highest in the nation. New York, with 130 patients per 100,000 population, ranks first and Arkansas, with nine, ranks last among all states.

With the exception of North Dakota, the top ten ranked states are eastern states which generally have had a longer history of maintaining state mental hospital systems. Seven of ten lowest ranked states are western or mid-western states.

From a study of the data in tables 15 and 16, it may be concluded that the variation in number of patients per 100,000 population dominates expenditures per patient in explaining the variation among states in total mental hospital expenditures per capita. Expenditures per patient exhibit a significantly narrower range than the number of patients per population unit.[12] Hence, it appears that budgetary control over total mental hospital expenditures is likely to be exercised via changes in patient load. There is little evidence of economies of scale; any significant increase in total patient population would probably result in a roughly proportionate increase in total expenditures.

Table 17 shows, by state, full-time equivalent total staff and full-time equivalent patient care staff in state mental hospitals, average daily inpatient census and patient care staff per inpatient for 1983. Nationally, the patient care staff accounts for 65 percent of the total hospital staff and averages 1.04 per inpatient. In

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[12]For example, the ratio of the average number of patients per 100,000 population for the five highest ranked states to the average for the five lowest ranked states is 5.8, whereas the comparable ratio for average expenditures per patient is 3.2.

Table 17

FULL-TIME EQUIVALENT STATE MENTAL HOSPITAL STAFF,
FULL-TIME EQUIVALENT PATIENT CARE STAFF,
INPATIENT CENSUS
AND RATIO OF PATIENT CARE STAFF TO INPATIENTS,
BY STATE, 1983

State	Total FTE staff July 1983	FTE patient care staff July 1983	Average daily inpatient census	Patient care staff per inpatient	Rank by patient care staff per inpatient
Alabama	2,790	1,777	2,077	0.86	47
Alaska	271	181	170	1.06	25
Arizona	562	352	336	1.05	29
Arkansas	890	364	285	1.28	8
California	9,052	5,685	5,895	0.96	36
Colorado	1,875	1,076	847	1.27	9
Connecticut	3,574	2,323	2,341	0.99	32
Delaware	853	485	517	0.94	39
Florida	5,816	4,071	3,748	1.09	21
Georgia	7,901	5,965	4,257	1.40	7
Hawaii	392	263	239	1.10	20
Idaho	311	190	171	1.11	18
Illinois	6,072	3,838	4,014	0.96	38
Indiana	3,319	2,177	2,342	0.93	41
Iowa	1,598	1,012	853	1.19	13
Kansas	2,090	1,350	1,286	1.05	28
Kentucky	1,505	856	803	1.07	24
Louisiana	3,138	2,115	1,757	1.20	11
Maine	1,101	708	590	1.20	12
Maryland	4,630	3,130	2,770	1.13	16
Massachusetts	4,153	2,749	2,481	1.11	19
Michigan	5,629	4,047	4,105	0.99	33
Minnesota	2,241	1,596	1,527	1.05	30
Mississippi	1,791	1,075	1,739	0.62	50
Missouri	5,316	3,179	2,187	1.45	4
Montana	521	336	344	0.98	34
Nebraska	1,280	867	602	1.44	5
Nevada	502	317	82	3.87	1
New Hampshire	1,057	740	517	1.43	6
New Jersey	6,465	4,306	4,616	0.93	40
New Mexico	810	523	218	2.40	2
New York	34,839	23,516	23,692	0.99	31
North Carolina	5,382	3,224	2,992	1.08	23
North Dakota	699	484	526	0.92	42
Ohio	7,027	4,582	4,304	1.06	26
Oklahoma	2,418	1,448	1,221	1.19	14
Oregon	1,080	737	837	0.88	44
PENNSYLVANIA	12,615	8,011	8,804	0.91	43
Rhode Island	908	456	421	1.08	22
South Carolina	3,210	2,546	2,928	0.87	45
South Dakota	658	447	377	1.19	15
Tennessee	3,257	1,928	1,822	1.06	27
Texas	9,883	6,068	5,411	1.12	17
Utah	502	282	294	0.96	37
Vermont	355	243	193	1.26	10
Virginia	5,588	3,548	3,652	0.97	35
Washington	1,573	1,078	1,257	0.86	46
West Virginia	1,417	820	1,022	0.80	49
Wisconsin	2,690	1,676	944	1.78	3
Wyoming	429	227	278	0.82	48
United States	182,035	118,974	114,691	1.04	--

SOURCE: S. Greene, M.J. Witkin, J. Atay, A. Fell and R.W. Manderschied, State and County Mental Hospitals, United States, 1982-83 and 1983-84, National Institute of Mental Health, Statistical No. 176, July 1986.

Pennsylvania, the 8,000 patient care staff represents .91 care staff per inpatient which places the Commonwealth among the eight lowest ranked states.

The variation in care staff per inpatient, however, is very limited. Of the 50 states, 42 fall within plus or minus 25 percent of the national average ratio. Since the care staff is the most costly component of operating expenditures, the relative stability of the care staff-inpatient ratio imparts stability to per-inpatient expenditures. Also opportunities for economies of scale are apparently limited by the nature of staff requirements so that large states find no relative cost advantage in operating large mental hospital systems.

The average length of stay in 1983 of inpatients at the state mental hospitals is shown in table 18. The average stay for all states is 92 days and the average ranges from a low of 26 days in Nevada to a high of 210 days in West Virginia. Pennsylvania ranks second highest in the nation with an average length of stay of 202 days per inpatient. Average length of stay is calculated by dividing the number of inpatient days by the sum of the number of inpatients at the beginning of the year and the number of inpatient additions during the year. Additions during the year include admissions and readmissions, as well as returns from long-term leave and transfers from noninpatient hospital status.[13] Average length of stay is the

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[13]S. Green, et al., State and County Mental Hospitals, United States, 1982-83 and 1983-84, National Institute of Mental Health, Statistical No. 176, p. 10.

Table 18

AVERAGE LENGTH OF STAY OF INPATIENTS AT STATE MENTAL HOSPITALS BY STATE AND STATE RANK, 1983

State	Average length of stay in days[1]	State rank
Alabama	142	5
Alaska	53	44
Arizona	139	7
Arkansas	31	48
California	117	11
Colorado	94	21
Connecticut	65	37
Delaware	75	30
Florida	179	3
Georgia	50	46
Hawaii	57	40
Idaho	75	31
Illinois	54	42
Indiana	109	12
Iowa	52	45
Kansas	101	14
Kentucky	58	39
Louisiana	72	33
Maine	83	27
Maryland	94	20
Massachusetts	91	22
Michigan	90	23
Minnesota	85	26
Mississippi	89	25
Missouri	53	43
Montana	120	10
Nebraska	69	34
Nevada	26	50
New Hampshire	131	9
New Jersey	134	8
New Mexico	76	29
New York	150	4
North Carolina	72	32
North Dakota	55	41
Ohio	81	28
Oklahoma	42	47
Oregon	64	38
PENNSYLVANIA	202	2
Rhode Island	99	17
South Carolina	100	16
South Dakota	104	13
Tennessee	68	35
Texas	66	36
Utah	140	6
Vermont	96	18
Virginia	100	15
Washington	89	24
West Virginia	210	1
Wisconsin	28	49
Wyoming	96	19
United States	92	--

1. Average length of stay is calculated by dividing the number of inpatient days by the sum of the number of inpatients at the beginning of the year, and the number of inpatient additions during the year.

SOURCE: S. Greene, M. J. Witkin, J. Atay, A. Fell and R. W. Manderschied, State and County Mental Hospitals, United States, 1982-83 and 1983-84, National Institute of Mental Health, Statistical Note No. 176, July 1986, Table 6.

inverse of the usual concept of an annual turnover rate. Thus, an average stay of one-third of a year (365/3) days is equivalent to a turnover rate of three.

The Commonwealth's high average length of stay stems from a relatively low rate of additions. Pennsylvania and West Virginia have been the only two states in the nation where the annual number of additions to the state mental hospitals is smaller than the inpatients at the beginning of the year.

The high average length of stay belies the notion that Pennsylvania's mental health hospitals exhibit a revolving door syndrome that is mentioned so often in oral and written testimony given at task force hearings. Although the revolving door no doubt refers to the cycle of admission, release and readmission of an individual patient, Pennsylvania exhibits a low rate of turnover for the inpatient population as a whole. Wisconsin, assigned the highest quality rating among all state programs by Torrey and Wolfe, is a clear example of a revolving door state. In 1983, the patient count at the beginning of the year was 885 while 11,473 additions occurred during the year. The average length of stay in Wisconsin, second lowest in the nation, is only 28 days.

One reason for Pennsylvania's relatively high average length of stay is the large number of long-term care patients (LTCs) in the state mental hospitals. The LTC patients are not usually under legal compulsion to stay in the hospital but, as older persons with a long history of hospitalization, have few public alternatives. Most of

these patients receive care similar to that of residents in geriatric facilities.

The number of long-term care patients is gradually falling. The October 31, 1986 census indicates that there were 1,728 LTCs, a drop of 882 patients from the June 30, 1984 count of 2,510 LTCs. The number of LTCs in the January 1987 patient count is not precisely known, but an estimate of 1,700 LTC patients appears reasonable according to the Department of Public Welfare.

The presence of a large number of LTC patients in the census count raises the average length of stay for Pennsylvania mental hospitals because LTCs usually stay a full 365 days a year. If the estimated number of LTC patients is subtracted from total patient days and patient count, the average length of stay for the non-LTC patients becomes 168. Pennsylvania would still rank fourth among the states on the basis of a 168 day average length of stay.

REFERENCE NOTE

Torrey and Wolfe utilized a broad data base to determine state rankings. Their data included surveys of the state psychiatric hospitals by the Health Care Financing Administration and the Joint Commission on Accreditation of Hospitals; surveys by the state departments of mental health, family consumer groups and expatient groups; investigations by the National Institute of Mental Health and

the Department of Justice; and interviews with experts. The criteria used to rate the hospital services include adequacy of staffing, physical and neurological exams, treatment plans and the overall appearance of the wards. The criteria used to evaluate the community-based system include the availability of housing and psychological rehabilitation, coordination of follow-up care and involvement of patient families.

To arrive at their ranking, Torrey and Wolfe gave each state a composite score of one to five, for both state mental hospitals and community-based systems, with one being the lowest and five the highest. These two scores were then added together to get a sum of two to nine (no state received a perfect ten). States with equal scores were ranked inversely by per capita income in order to get a ranking for all 50 states.

V. Recommendations

Recommendations to improve the Commonwealth's mental health system are implemented in the proposed Mental Health and Mental Retardation Code. They include changes in both the service delivery system and commitment procedures as well as in funding and patients' rights that complement those proposals. The sections of the proposed Code that incorporate each proposal are noted parenthetically where appropriate.

SERVICE DELIVERY SYSTEM

Integration and Coordination of Services

Throughout the course of the task force's public hearings, many concerns were raised regarding the lack of coordination between State hospitals and community programs, as well as with the various aspects of the community programs. Numerous witnesses stressed the importance of a closer working relationship between community and institutional service delivery systems. Union representatives and employees of State hospitals recommended a larger role for the staff of State hospitals in providing follow-up and community outreach services; other clinicians identified the need for regional planning in the

delivery of mental health services as a way to increase the continuity of care to clients and their families. Family members and former clients vividly portrayed the failures of a disjointed system that lacks adequate case management and follow-up services to monitor the progress of clients.

The Mental Health and Mental Retardation Act of 1966 outlines State and county responsibilities. No section of the statute addresses joint coordinated services for clients. The current law requires the Department of Public Welfare to appoint regional mental health and retardation boards as may be necessary to advise the department in the establishment, administration and review of mental health and mental retardation programs; this has not been implemented.

In order to address these problems, service area Conjoint Boards are recommended (Code § 313). These boards would be composed of representatives appointed from the State hospital boards of trustees and the county mental health and mental retardation programs, including county administrators; representation from consumers of mental health services, family members, advocates and mental health review officers would be required. Each board would make recommendations to the department on matters pertaining to the integration of services with community programs and joint regional planning. They would also participate in the process of appointing superintendents of the State institutions.

To insure that a comprehensive array of services is available in the counties the State hospital serves, the State facilities would

be redesigned to provide those inpatient services that the individual counties are not able to provide (Code § 301(9)).

State hospitals are now required to refer persons who are about to be discharged to county programs for follow-up care. This would be expanded to require all public and private inpatient facilities to refer persons receiving publicly funded mental health services to the appropriate county program for follow-up care (Code § 916).

These recommendations ensure that (1) a full range of services are available to every region of the Commonwealth and (2) persons will be able to access these services. To further ensure the accessibility of services to persons needing them, case management and intensive case management services are specifically mandated.

Case Management

Witnesses at all the public hearings urged the establishment of case management services to assist the mentally ill in obtaining services. Case management services are currently not specifically mandated in the Mental Health and Mental Retardation Act of 1966; however, counties are required to provide care to patients through base service units. See 55 Pa. Code § 5221. Various types of assistance are specified to ensure that the mentally ill receive continuity of care (Code § 501(c)(10)).

Intensive case management services for mentally ill persons who have threatened or perpetrated violence and for those who require a

disproportionate share of services is also recommended (Code § 501(c)(11)). This special type of case management includes continuous individualized assistance.

Examination of various service delivery systems in different states, including North Carolina, Washington, Arizona, Hawaii and Wisconsin, supports the claim that intensive case management services provided by trained case workers with small case loads can maintain the mentally ill in their communities. The Dane County, Wisconsin model that has case workers monitoring clients' programs, appears to be particularly effective in attempting to keep the mentally ill out of institutional care and stabilized in the community.

To offset the cost of such a labor intensive service, the Department of Public Welfare is negotiating with the federal Medicaid office to have the State medical assistance plan amended to cover case management services.

State Hospital Management

The role of the State hospital is not elaborated upon in the Mental Health and Mental Retardation Act of 1966. The statute states that the department "shall assign such functions as the secretary shall prescribe" to State facilities.

As discussed above, it is recommended that joint planning take place between State institutional and county mental health staff. The

proposed Code elaborates on the role of the State hospital (Code § 301(9)) and sets forth the minimum standards for State facilities (Code § 301(9)). This proposal should also address institutional system concerns regarding loss of federal funding because of failures to meet accreditation standards.

Patients Rights/Advocacy

The confidentiality provisions of the current law are proposed to be amended to permit the release of information in certain circumstances. In the area of patients' rights and advocacy, proposed exceptions to strict confidentiality would allow greater involvement of family members in the treatment process. This change would conform with the 1986 Guidelines for Involuntary Civil Commitment developed by the National Task Force on Guidelines for Involuntary Civil Commitment which concludes that family members should be viewed as partners in the treatment of their relatives. Specifically, treatment personnel would be authorized to communicate with family or household members for treatment purposes (Code § 112(c)(1)).

Testimony indicated that, at least in some areas, confidentiality restrictions are read so narrowly as to preclude contact by treatment personnel even when necessary for treatment purposes. Another exception addresses complaints that confidentiality concerns have been used to exclude family and household members from receiving such basic information as the mentally ill person's location

and general status (Code § 112(c)(2)). Under the present law, family members are not allowed to receive general information about a patient's condition, regardless of how well intended the requests are, unless the patient provides written consent. This exception would allow the release of the information unless the patient has previously objected to its release in writing.

Accessibility to patients' records are conformed by the proposal to the requirements of the Federal Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-139, 42 U.S.C.A. § 10801 et seq.) (Code § 112(b)(5)).

Several recommendations would aid in the protection of patient rights. One proposal would expand the external advocate program that the department has established at Philadelphia, Clarks Summit, Mayview and Woodville State Hospitals (Code § 301(13)). The pilot program has proven successful in helping to ensure that those persons assigned an advocate receive appropriate services as outlined in their treatment plans. These independent overseers represent their clients' interests during their stay in care.

It is proposed that the Commonwealth take a more aggressive role in fighting to eliminate the stigma surrounding mental illness (Code § 301(14)). The Department of Public Welfare has begun to address these concerns by funding a State office of the National Mental Health Consumers Association. Local mental health administrators, as well as State mental health officials, continue to speak out at public forums on possible misconceptions concerning

mental illness. Their efforts have been assisted by the Pennsylvania Alliance for the Mentally Ill, an advocacy organization composed of family members of the mentally ill.

Public testimony was also received regarding the need for more consumer and family run self-help groups. The Office of Mental Health has funded a statewide office for families to serve as a resource office and information exchange; this proposal will encourage further efforts of this type (Code § 301(15)).

The Commonwealth's Patients' Bill of Rights, now included in regulations (55 Pa. Code Ch. 5100), and provisions from the Philadelphia County Mental Health and Mental Retardation Program Bill of Rights would be incorporated into the Code (Code § 2503).

The statutory bill of rights would extend coverage to all mentally ill persons receiving treatment, whether an individual is an inpatient, outpatient or receiving partial hospitalization services.

By incorporating a bill of rights into the revised mental health law, the rights guaranteed the mentally ill in Pennsylvania would become more readily available to the legal community, would obtain a greater degree of importance and could only be amended by an act of the General Assembly. Additionally, the State system established under the Federal Protection and Advocacy for Mentally Ill Individuals Act of 1986 is authorized to assist mentally ill persons in protecting their rights.

Training

Witnesses at all the hearings mentioned the lack of training as a major flaw in the mental health system. These witnesses represented a diverse group of clinicians, police, court officers and advocates for the mentally ill. They attributed the inconsistent application of the procedural law to a lack of training for staff, including the police, public defenders, hearing officers, as well as mental health professionals.

Under existing law, training is an optional service for county mental health and mental retardation programs and is not specifically mandated in the department's duties.

Currently, the Commonwealth provides funds directly to Western State Psychiatric Institute and Clinic, Central Pennsylvania Psychiatric Institute and Eastern Pennsylvania Psychiatric Institute to offer mental health education throughout the State to mental health clinicians. Staff from the three facilities provide clinical and management training to State institutional and community agency staff. In addition, the mental health procedure regulations now require the department to "make available training to (mental health review officers and court officials) to aid them in carrying out their duties." (55 Pa. Code 5100.21(a)) These regulations do not prescribe the extent or content of training.

Based on these findings, as well as the recommendations received during the hearings, it is proposed that the department establish statewide training standards and provide training for personnel involved in the delivery of mental health services. Police, emergency service workers, ambulance personnel, State and community hospital personnel, court personnel and service providers as well as consumers and families would be included (Code § 301(6)). Moreover, the county mental health and mental retardation units would be required to ensure that their staffs receive the mandated training programs established by the State (Code § 501(c)(13), (d)).

Funding

In order to encourage the development of certain community programs, they have been included in the provision requiring 100 percent State funding. These services would become mandated services for county mental health units. These include three types of partial hospitalization (acute care up to 60 days, intermediate rehabilitative care not exceeding 120 days per year and extended care) (Code § 127(3)).

The disincentive for the development of alternatives to short term hospitalization and institutional care results in large part from the requirement that the counties provide matching funds in order to obtain State funding. At the full funding level, there is an incentive for county mental health officials to utilize inpatient

facilities in preference to community alternatives funded at the 90 percent level. Therefore it is proposed that inpatient care not be reimbursed at the 100 percent funding rate (Code § 127(3)).

Residential services, including short-term services as an alternative to hospitalization, intermediate services for rehabilitation and indefinite extended care are proposed to be funded at the 100 percent level (Code § 127(5)), as is mandated training (Code § 127(6)).

Current statutory provisions discourage private gifts or grants to local mental health programs. The State treats such revenue as a local contribution and reduces its share of funding accordingly. Under the proposed change, private dollars received by county programs would not be considered in calculating the Commonwealth's obligation (Code § 129(1)).

Use of purchase of service contracts to obtain community services is currently authorized, and the proposal found in section 501(e) of the proposed Code is intended to encourage additional private providers to serve more mentally ill clients referred from the public sector. The Department of Public Welfare intends to provide management training to counties to assist local officials in establishing proper contractual arrangements.

Services in General

Language specifically describing the types of mandated county services would be deleted as it has been interpreted to limit those

services to the ones enumerated in the act. General functional descriptions are substituted for specific service descriptions, since specific services can change over a period of time (Code §§ 501(c)(5)-(7)).

Residential services have been added to the mandated county-provided services. (See discussion above at "Funding.") Residential services are currently time limited in nature and people who do not improve are not accepted for care or are released from care prematurely. This section recognizes the importance of lifetime care for many chronically mentally ill clients in residential programs. Currently, there is no way to provide this indefinite care and receive State reimbursement (Code § 501(c)(12)).

COMMITMENTS

Coordination of Services

After the Mental Health Procedures Act became effective in 1976, programs were initiated at the community level, in State facilities for the mentally ill and at the State administrative level to ensure that the law would be properly implemented. Many witnesses attested to the fact, however, that the act is not uniformly followed across the State. Consequently, different criteria are used in various parts of the State to invoke involuntary treatment.

Moreover, there is a lack of coordination between the mental health and correctional systems. Court officials complain about their inability to obtain adequate mental health services for prisoners.

The establishment of a central bureau in the Office of Mental Health, which would have the responsibility for ensuring uniform admission practices across the State, and a mental health system that dovetails at appropriate points with the State's correctional system, is recommended (Code § 303). The functions of the bureau would include record maintenance, data collection, policy development, coordination of services between the mental health and correctional systems, training and the provision of a 24-hour telephone service.

Criteria

A thorough review of the many recommendations which called for changes to the involuntary commitment criteria prompted proposals to modify the "dangerousness" standard to ensure that a small but significant number of persons in critical need of mental health services who now do not receive treatment are served.

The first proposed change would expand the definition of severely mentally disabled to include those who, as a result of mental illness, pose a clear and present danger of substantial property damage (Code § 1301(a)). Arizona, Hawaii and Kansas include similar language in their mental health statutes.

A second proposed change eliminates "serious" from bodily harm to another (Code § 1301(b)). Witnesses pointed out that those persons authorized to make treatment decisions often could not determine what constituted serious bodily harm and, consequently, delayed authorizing treatment. This change should bring about earlier intervention.

The third recommended change deletes "death" and "serious" bodily injury when considering if a person is a clear and present danger to self (Code § 1301(c)). Sufficient evidence supported the claim that people have been denied treatment because it was felt that their condition was not serious enough. The change should also encourage earlier intervention.

A fourth change in the "dangerousness" standard extends to 60 days from 30 the time period in which behavior of an individual can be considered prior to an order for involuntary treatment (Code § 1301(b)). Critics of the current language in the statute have expressed concerns that without an expanded time period it is often difficult to make an accurate medical assessment of a person's behavior.

In evaluating the conduct of persons "detained because of pending criminal charges" the proposed 60-day time period in which to evaluate behavior is waived, provided that an application for examination and treatment is filed within 30 days after the date of release from detention (Code § 1301(b)). This is consistent with the treatment of persons found to be incompetent to stand trial or acquitted by reason of lack of criminal responsibility.

Witnesses urged removal of the current requirement that an overt act be present before dangerousness can be proved. The overt act requirement has generally been maintained however. The proposal would waive the requirement in the limited event that a reasonable probability exists that threats may be acted upon by a person who has

a history of similar behavior (Code § 1301(d)). Additionally, it is proposed that past behavior and medical history be specifically included as relevant evidence in determining whether a person is severely mentally disabled and "poses a clear and present danger of harm to others or to self or of substantial damage to real or personal property" (Code § 1301(a)).

Initial Commitments

It is proposed that licensed, doctorate-level psychologists be granted authority to petition for involuntary emergency examination and treatment. The current statute allows only physicians, the county administrator or his designee, or a police officer to initiate emergency evaluation and treatment (Code § 1302).

The initial examination and treatment period, which currently cannot exceed 120 hours, has been changed to five business days to address the unavailability of medical and court personnel over weekends and during holidays.

While some clinicians requested up to 14 or 15 days for the initial period of treatment, the task force decided in favor of five business days. This modest revision is intended to take into consideration time constraints that can prevent accurate evaluation and diagnosis, while avoiding excessive confinement (Code § 1302).

The current requirement that a person authorized to order an involuntary examination and treatment must personally observe the conduct showing the need for treatment is considered an excessive

impediment. The frustration witnesses expressed about the difficulty they had obtaining services for a family member brought about this recommended change which permits the use of statements made by a mentally ill person in authorizing involuntary emergency examination and treatment (Code § 1302(c)).

An additional proposal would require county administrators to have the sole responsibility for protecting the property of persons in treatment. Previously, the duty was imposed on the administrator or the director of a facility, which sometimes resulted in losses of property due to uncertainty as to which person was assuming the responsibility (Code § 1302(f)).

Outpatient Commitment

Outpatient treatment has been a treatment option under present law, but the 1976 act does not specify when its use is appropriate nor does it provide procedures to return a person to inpatient treatment should it become necessary. It is proposed to permit the transfer of inpatients to outpatient treatment if they are not imminently dangerous (Code § 1302(g), 1306(d), 1307). The proposal resulted, in part, from a study of the outpatient commitment statutes of Hawaii and North Carolina.

In the event a person seriously deteriorates under outpatient treatment, the director of the facility or the county administrator may petition the court for a hearing under section 306 and to transfer

the patient to an appropriate facility for detention pending the hearing which shall be held within 72 hours.

These procedures were initially provided in Mental Health Bulletin 99-86-14, dated May 8, 1986. Codifying these provisions should provide more uniformity in the implementation of outpatient procedures throughout the State. Currently, some county mental health professionals are reluctant to recommend involuntary outpatient care in view of the limited statutory authority.

Proceedings

It is recommended that mental health review officers be provided the authority to certify and order involuntary examinations and treatment (Code § 921(a)). Currently, judicial approval of the review officer's certification is required, which sometimes results in delays in the appeal process or in initiating treatment. The right to appeal the decision of the hearing officer to the court is retained.

Additional Periods

This proposal is intended to clarify the original intent of the language authorizing additional periods of treatment. Although intended to require a showing of some evidence indicating a continuing need for treatment, this provision has been interpreted to require a new showing of dangerous behavior (Code § 1305(a)).

Persons Incompetent to Stand Trial or Serving Sentence

Several offenses have been added to the list of offenses that can result in court-ordered involuntary treatment for up to one year. These arson-related offenses include (a) arson endangering persons; (b) arson endangering property; and (c) reckless burning or exploding. These acts are considered by law officials to be of a serious enough nature to warrant the 12-month placement.

Attempts at these offenses and the others currently in the law (murder, voluntary manslaughter, aggravated assault, kidnapping, rape, involuntary deviate sexual intercourse and arson) will also be sufficient to certify a mentally ill person for one year in involuntary treatment (Code § 1304(g)).

Additionally, treatment of persons charged with a crime or undergoing sentence can be expedited by authorizing treatment for such a person under section 1304 of the Code (court-ordered treatment not to exceed 90 days) following treatment under section 1302 (not to exceed five business days), without an intervening period of treatment under section 1303 (not to exceed 20 days) (Code § 1501).

Other Commitment Issues

It is intended that by changing the language in the statement of policy found in the 1976 act from the use of the least restrictive alternative consistent with "adequate" treatment to consistent with

treatment "appropriate to the individual's needs," mentally ill persons will be placed in treatment settings more carefully tailored to their needs.

OTHER ISSUES

Law Enforcement Concerns

It is recommended that four areas of the confidentiality of records provisions be modified. Under the present confidentiality requirements of the Mental Health Procedures Act, there is no way to obtain records of a defendant for a pretrial hearing or for any other hearing unless the judge is conducting a mental health competency hearing. Also, if a defendant is released on bail and a condition of continued bail is verification that the individual is receiving treatment, there currently is no way for the court to obtain this information without the consent of the defendant. Therefore, it is proposed that judges be authorized to access records during criminal proceedings in which a person's mental condition is an issue (Code § 112(b)(3)).

As a result of the strict nature of the confidentiality provisions, law enforcement officials have no access to information regarding a potentially dangerous person's mental health records. Proposed section 112(c)(3) authorizes the director of a mental health facility to decide if there is an emergency situation warranting the release of relevant information about a client to the police.

During the hearings it became apparent that the current mental health procedures law contains confidentiality protection to such a degree that treatment staff have not been allowed to provide warnings to potential victims of dangerous or potentially dangerous patients. A number of individuals testified about relatives returning from mental health centers and subsequently harming family members. Proposed section 112(c)(4) allows responsible treatment personnel to warn certain persons or the police if they believe that a patient will carry out threats.

A California case, Tarasoff v. Regents of the University of California, 131 Cal. Reptr. 14, 551 P.2d 334 (1976), greatly influenced this recommendation. The court ruled in behalf of a family who sued a hospital and its staff for failure to notify an ex-girlfriend of a mentally ill patient about his threats against her life. The patient subsequently murdered the woman. The court imposed "a duty to warn" on hospital staff who learn of such threats. The proposed change to the Pennsylvania statute would allow "an option to warn." Mandatory reporting would not be necessary. The decision to report would be made by the hospital staff. This decision has not yet been adopted in Pennsylvania but has been in other jurisdictions. If a threat is believed to be one affecting the public safety, warnings to the police are authorized (Code § 112(c)(5)).

Testimony was received regarding a number of instances where persons demonstrating mentally ill behavior that constituted a violation of the law had been brought into a mental health center for

examination and released without any official of the center notifying the police. It is believed that if a person, found not to be in need of treatment, has committed criminal acts, that person should be detained and police notified so that criminal charges can be filed if appropriate (Code § 1302(d)).

Commissioner of Mental Health

Act No. 32, enacted July 9, 1987, eliminated the requirement that the Commissioner of Mental Health be a psychiatrist. While bringing Pennsylvania in line with other states (only Oklahoma requires a psychiatrist to head its program), it failed to provide minimal educational and experience requirements. This is in sharp contrast to specific qualifications established in current regulations (55 Pa. Code § 4200.33) for county mental health administrators.

It is recommended that minimum qualifications for the position of commissioner be established and that the State be required to employ a psychiatrist as Deputy Commissioner for Clinical Services, if the commissioner is not a psychiatrist (Code § 302).

FISCAL NOTES ON PROPOSED RECOMMENDATIONS

The following fiscal projections are based on information provided by the Department of Public Welfare.

As stated earlier, Pennsylvania has the second highest per capita expenditures for mental health services in the nation. Recommending policies which may result in significant increases in

costs does not imply that there exists no opportunity to redirect existing resources to finance recommended reforms.

In order to significantly improve services while containing costs, the mental health system will have to reevaluate its long-term goals and objectives in the area of revenue enhancement, prioritizing patient populations, reducing lengths of stay in State mental hospitals and improving fiscal and program management strategies. The Department of Public Welfare has considerable flexibility in the appropriation process for mental health services. It is hoped that these recommendations will encourage the department to use that flexibility to set new directions and improve the quality of services in a fiscally responsible manner.

Fiscal Impact of Specific Recommendations

County expenditures for residential services are reimbursed 90 percent by the State. The proposed amendment to section 127(6) would reimburse these expenditures 100 percent. Based on 1985-86 allocations, the State would be required to increase the reimbursement for residential services by $2,700,000 to maintain existing services at the current level. Offsetting part of this cost increase is the proposed reduction in State payments to counties for inpatient services in section 127(3) from 100 to 90 percent, yielding estimated savings of $700,000. The net increase of $2,000,000 in reimbursement for county residential services does not reflect the long-term effects of the change in reimbursement rates on service demand.

In 1985-86, the State allocated approximately $2,000,000 for training activities. In order to establish statewide training standards as the proposed amendment to section 301(6) requires, Office of Mental Health staffing levels would need to be increased at a cost of $150,000 annually. The recommendation to add training to the list of mandated mental health services in section 501(c)(13) would require the State to establish a cost center for training activities. Training activities would be State reimbursed at 100 percent at a cost of $2,000,000 annually over a phase-in period of two years.

The proposed amendment to section 301(13) requiring external advocacy services for patients at all State mental hospitals is estimated to cost $640,000 annually.

To establish and operate a Bureau of Admissions Services, offer and conduct training and maintain a 24-hour telephone service as proposed in section 303 would cost $250,000 per year. By eliminating the Commonwealth Mental Health Research Foundation, a savings of $50,000 could be applied to this bureau. The foundation created by the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, has been dormant since 1976. The net cost for implementing this proposal is $200,000 per year.

The costs for case management services proposed in section 501(c)(10) and (11) are calculated on the basis of a significant increase in intensive case management services for approximately 30,000 chronically mentally ill persons. Intensive case management would require 1,000 case managers; the remaining regular service could be provided by 425 case managers. The gross cost for implementing

this proposal is assumed to be substantially decreased by approval of the State Medical Assistance Plan amendment and revenue enhancement programs for additional case management services. The total net increase over the existing State allocation of $15.1 million would be $10.5 million per year phased in over three years.

Two major recommendations have significant fiscal impact in the area of involuntary treatment. Section 1301(a) and (b) adds substantial property damage to the grounds for commitment; and (d) adds threats and the reasonable probability, based on past behavior, that the threats may be acted upon.

Based on existing involuntary commitment data, the adoption of these proposals could produce a 35 percent increase in commitments (or 7,700 patients) to community inpatient facilities or State mental hospitals over a three-year period. While 25 percent of the existing emergency commitments continue on to longer term commitments in State hospitals, a broadening of existing criteria which provide for early intervention and an expansion of involuntary outpatient procedures should keep the long-term carryover rate at 10 percent.

Currently, approximately 90 percent of all emergency commitments go to community inpatient facilities. An increase in the admission rate could result in a 50-50 split between community and State hospitals. The net cost increase, based on 7,700 new admissions, a 50-50 split and with 10 percent of the patients continuing on for longer term commitments, is approximately $28 million annually phased in over three years.

If State hospital admissions are increased, there would be an additional one-time cost to open new State beds of $1.7 million.

Summary of Estimated State
Cost Increases

Service and Code section	1st year (1988-89)	2nd year	3rd year
100% residential costs by State net of savings on inpatients § 127(6)	2,000,000	2,000,000	2,000,000
Mandatory training §§ 301(6) and 501(c)(13)	$1,150,000	$2,150,000	$2,150,000
External advocates § 301(13)	640,000	640,000	640,000
Bureau of Admissions Services § 303(a) and (b)(5)	200,000	200,000	200,000
Intensive case management less additional federal funding § 501(c)(11)	3,300,000	5,900,000	10,500,000
Involuntary treatment net of additional federal funds and outpatient savings § 1301(a), (b) and (d)	12,000,000	21,000,000	28,000,000
Total	$19,190,000	$31,890,000	$43,490,000

RECOMMENDATIONS OF THE ADVISORY COMMITTEE ON MENTAL HEALTH LAWS

The Advisory Committee on Mental Health Laws made several recommendations to the General Assembly at large and to the Department of Public Welfare. The Task Force on Mental Health Laws, which did not adopt these recommendations, has directed that they be included in this report.

The advisory committee recommends that the General Assembly:

-- Pass House Bill 364 (1987), which mandates nondiscrimination in health insurance for mental illness.

-- Allocate additional funds to the State mental health budget to fund innovative mental health treatment programs. County mental health programs willing to devise such projects would be required to compete for these funds.

-- Given the apparent insufficiency in funds appropriated for the State mental hospitals, provide additional funds so as to assure the safe, efficient and adequate care of patients being cared for within the State hospital system.

-- Cost out and fund programs it authorizes.

The advisory committee recommends that the Department of Public Welfare:

-- Develop a mechanism to increase access to general and private psychiatric hospitals by creating short-term intensive care units at these facilities that would be reimbursed at a higher rate.

-- Relocate mentally retarded or substance abusive patients who lack a coexisting psychiatric disorder from State hospitals to more suitable facilities.

-- Use the resources available to the department to complement the services of the counties to insure a coordinated, comprehensive array of services providing continuity of care to all residents of counties.

- -- Ensure that the mental health system provides patients with multiple diagnoses appropriate care.
- -- Review and revise the current fiscal regulations to the end of achieving a more equitable balance between accountability of funds and accountability established by quality of services. In pursuit of this objective, the department should make every effort to simplify these regulations as far as possible--and wherever possible in keeping with sound fiscal accountability, remove barriers to flexible and creative programming.
- -- Establish long-term care facilities to provide therapeutic, sheltered community settings for voluntary patients. These facilities would serve as an intermediate-level residential setting between community residential rehabilitation facilities and State hospitals.
- -- Design a long-term planning process at the State and local level to allow input from various interest groups in the formative stages of plan development. The Advisory Committee for Mental Health and Mental Retardation should be more representative of families, consumers, advocates and direct service providers.
- -- Examine within the Office of Mental Health alternatives to Commonwealth management of any or all of the existing State hospitals.

-- Use Medicaid and Medicare funding creatively to bring additional federal funds into the State. This may involve renegotiation of State-federal contracts in some instances.

-- Reduce the paperwork and committee meeting burden of professional staff at State mental hospitals. Intervention in this matter could occur at the level of the Joint Commission on Accreditation of Hospitals or Medicare, both of which mandate many specific activities for State hospitals. It should be noted that information has been received regarding initial efforts in this area by the Joint Commission on Accreditation of Hospitals and the Health Care Financing Administration. Other interventions could involve information collection in a manner that is more efficient and thus would require less professional time. Confidentiality considerations should be addressed to avoid release of sensitive psychiatric data without the patient's permission.

-- Integrate federal and State funding administratively so that county programs can commission and pay for specified services for their clients. The Commonwealth would provide oversight; pilot efforts should be made initially.

-- Revise the patient liability regulations to make them less difficult to implement and burdensome to clients and service staff.

-- Establish oversight and technical assistance capabilities within the department to assist counties to accomplish the objective of the proposed amendment to section 501(e) relating to purchase of service arrangements.

MINORITY REPORTS

Senator Williams and Representative Josephs, while voting with the majority of the task force on approximately one-half of the recommendations, objected to certain proposals. Their statements in support of their objections follow.

STATEMENT BY

SENATOR HARDY WILLIAMS

I would respectfully disagree with the direction of the Advisory Committee report in that it is reactive and restrictive in approach.

It is my educated opinion, after having participated in the hearings, investigating extensive outside sources, consulting with the Department of Public Welfare, and gained the valued insights of members of the advisory committee and staff, that we must embark on a bold new direction, with a maximum of challenge and creativity.

This report of the Committee does not do that.

Accordingly, I am preparing a formal report to follow with recommendations in accordance with the above.

BLUEPRINT FOR A NIGHTMARE:

DISSENT FROM THE MAJORITY REPORT OF THE MENTAL HEALTH TASK FORCE

SENATE RESOLUTION 108

State Representative Babette Josephs
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prepared by Robert Hirtz

SUMMARY

The majority report of this task force dwells at great length on legislation which would ease our commitment laws in a variety of ways to make it much easier to commit Pennsylvanians to psychiatric treatment against their will.

This would be a grave mistake. Broadening involuntary commitment laws will put a greater burden on our public health system than it can bear now or in the forseeable future. Easing our current commitment standards will greatly harm the quality of care received by Pennsylvanians and will not better protect the public.

Insofar as it calls for the "reinstitutionalization" of mentally ill Pennsylvanians through broadening involuntary commitment laws, the majority report sets the stage for a return to wholesale warehousing in our state mental system.

Our public mental health system is already overburdened and underfunded. Since broadening involuntary commitment laws has been shown to guarantee a significant increase in involuntary commitments, the impact on Pennsylvania's public mental health system could be catastrophic.

Furthermore, the public will be no more protected from dangerous mentally ill persons than we are today.

THE MAJORITY'S PROPOSALS PUT THE PUBLIC AT GREATER RISK

Enacting the majority's recommendations may well increase the danger to the public from mentally ill persons: Psychiatry accepts the fact that dangerousness cannot be predicted, so, physicians will remain unable to predict whether or when a patient may commit a violent act, either before a commitment hearing, or upon release from a psychiatric facilitity.

In addition, reopening the floodgates to our state mental hospitals will ensure a further deterioration in the quality of care, so that more mentally ill persons may be released from our institutions more disturbed and more violent than when they entered.

Finally, budgetary increases in funding for state hospitals, necessitated by a larger patient census, will probably result in a shrinking of the state appropriations to community mental health services. As a result, poor persons with mental illness who live successfully in the community, but who temporarily experience a time of psychological crisis and seek out help from local mental health services, will be denied that help even more frequently than they are now.

The Springfield Mall shootings of 1985 provide a memorable case in point, where a mentally ill person, living on her own in the community, experienced psychological crises and, and according to testimony given to this Task Force, repeatedly sought help from community mental health programs. But the overburdened and underfunded community services in her area continually failed to respond.

MAJORITY RECOMMENDATIONS ENSURE UNJUST AND UNCONSTITUTIONAL COMMITMENTS

If the majority's legislation is adopted, involuntary psychiatric commitment would be warranted if a person "has made threats to commit harm, suicide or self-mutilation within the past 60 days and based upon past behavior there is a reasonable probability that the threats may be acted upon." (proposed section 1301 (d))

Under this proposed law, the responsibility for determining the future dangerousness of an individual would rest primarily on the predictive powers of a psychiatrist.

And yet, the American Psychiatric Association readily admits that psychiatry is incapable of predicting dangerousness. Dr. Bernard Diamond, an eminent University of California Professor of both Psychiatry as well as Law and Criminology, eloquently acknowledges this fact in his comprehensive review of the literature on the psychiatric prediction of dangerousness when he concludes:

> I know of no reports in the scientific literature which are supported by valid clinical experience and statistical evidence that describe psychological or physical signs or symptoms which can be reliably used to discriminate between the potentially dangerous and the harmless individual. The fact that certain signs may sometimes be associated with violent behavior, as, for example, certain types of abnormal brain waves, or that persons who have committed acts of violence tend to reveal in their past histories certain common features, such as an unusual exposure to violence in early childhood, or a higher than average incidence of childhood head injuries, in no way meets the legal need for criteria which will discriminate between the potentially violent and the harmless individual. (1)

If we start committing persons who merely "make threats to commit harm," as the majority report encourages, we will ensure that many persons will be inappropriately and unjustly preventatively detained in our state's psychiatric facilities.

Aside from depriving some considerable numbers of harmless eccentric persons of their liberty without cause, the majority's recommendations expose the commonweatlh to countless expensive, time consuming, and embarrassing lawsuits.

THE MAJORITY'S LEGISLATION ENSURES A RETURN TO WAREHOUSING

Despite the vast sums of money which Pennsylvania spends each year on our state mental hospitals ($308,856,000 appropriated for FY 87-88), we must spend still more to improve care and upgrade the physical plants of those institutions. According to officials at the Department of Public Welfare, several state mental hospitals in Pennsylvania require substantial improvements in order to maintain accreditation from the

Joint Commission on the Accreditation of Hospitals (JCAH). Loss of JCAH accreditation means a loss of federal funds to that institution, including Medicare and Medicaid funds, as well as any federal grant money.

Philadelphia State Hospital (PSH) is one of the state mental hospitals in jeopardy of losing its JCAH accreditation, according to a Blue Ribbon Committee appointed by the Secretary of Welfare. In it s September 1, 1987 report, the Committee denounced PSH, saying:

> ...poor organization and communication within the hospital are exemplified by the inconsiderate and inept handling of the Elsie R______ death [attributed to malnutrition]....The R______ case is not simply an isolated or outlandish set of circumstances but rather is indicative of the lack of coordination and outright omissions within the organizational structure at PSH. (2)

> ...the Blue Ribbon Committee recommends immediate and drastic action by the Department of Public Welfare and the commitment of the Secretary of Public Welfare to reverse the history of neglect, poor management, absence of treatment and rampant abuse. (3)

The findings of this Committee should serve as a sober warning: changing commitment laws will only excacerbate the problems encountered by PSH and other state institutions. It would be irresponsible to cause an abrupt increase in the patient census at PSH and elsewhere. Before we start filling that house with more people, we should put that house in order. As the Committee wrote in its September report:

> The Blue Ribbon Committee recognizes that there are approximately 531 patients at PSH at the present time and that for fiscal year 1986-87 $39,485,000 was appropriated and allocated for their care at PSH. We do not suggest that the amount is excessive or too little, but rather that such resources are not being aggressively, attentively, and effectively expended on appropriate care and treatment under a scheme of clinical and administrative accountability reasonably calculated to provide caring and adequate services to the patients, as well as providing for a safe and supportive treatment environment. (4)

Not only our state mental hospital system, but also other parts of our public mental health system are presently experiencing severe stress.

Philadelphia County provides an illustrative example. Between 1982 to 198[illegible] the number of patients handled by Philadelphia's emergency psychiatric services increased by 41%, and the number of hours of client contact with Philadelphia's emergency psychiatric services more than doubled. As shown in Table 1, between 1984 and 1985 the number of hours of patient contact increased by 45%, a vast increase in the demand for emergency services by any standard.

TABLE 1.

USE OF PHILADELPHIA PSYCHIATRIC EMERGENCY SERVICES
FISCAL YEARS 1982-1985 (5)

Fiscal Year	# of Contacts	# of Patients	Length of Contact (hrs)
1982-83	18,103	5,955	88,705
1983-84	19,499	6,464	103,345
1984-85	21,403	7,080	117,817
1985-86	26,851	8,400	170,542

Clearly, the demand for Philadelphia county emergency psychiatric services is exploding. It should be noted that the great majority of these patients are not ex-state hospital residents who have been "deinstitutionalized." In 1985, of the patients who received public mental health services from Philadelphia County's Emergency Services, more than 70% had never received psychiatric treatment at a state mental hospital. Of the "heavy users" of Philadelphia emergency psychiatric services (persons who were admitted to an emergency service three or more times during the year), 76% had no prior state mental hospitalization. (6)

Richard Surles, then Philadelphia County Administrator of the Office of Mental Health and Retardation, testifying before Philadelphia City Council, reported the following:

> The City Law Department also has experienced a rapid increase in court hearings for involuntary treatment of mentally ill persons. The Law Department reports that current daily court cases average over 20 hearings a day and on some days as many as 70 cases are present. Less than two years ago, court hearings were approximately 10 per day. (7)

THE MAJORITY REPORT IGNORES CATASTROPHIC FISCAL IMPLICATIONS

Pennsylvania can ill afford to turn back the clock and try to expand the role of state mental hospitals in our public mental health system: a recent national study showed that Pennsylvania had 51% more persons in state hospitals than the national average (74 per 100,000 civilian population in PA vs. the national average of 49). (8)

This helps to explain why Pennsylvania's per capita expenditures for mental health is second only to New York's. Whereas the national average in 1983 for per capita mental health expenditures in the United States was $33.23, Pennsylvanians were paying $59.28 per capita for mental health care, 56% more than the national average. (9)

To further compound the funding problems associated with our state hospitals, as of July 1, 1987, the start of the current fiscal year, our state mental hospitals were three hundred patients over budget. (10) This guaranteers that our state system will experience a budget shortfall that could surpass twenty million dollars, before the end of the current fiscal year.

Currently, on the average, there are about 7,800 persons in state mental hospitals in Pennsylvania. The average per diem for a state hospital resident is $166 per day, or $60,590 per year. If the average daily population of our state hospitals increased by just ten percent as the result of broadening our commitment laws, the costs of state hospital care to the taxpayers could increase by more than forty seven million dollars per year. (11)

The above figure of forty seven million dollars would not include the increased administrative and court costs of more commitment hearings, or the many millions of dollars in start-up costs which would be required to upgrade the physical plants at state hospitals before additional wards or beds could be opened up.

The Arizona state legislature eased that state's commitment laws at the start of FY 1983-1984. The average daily state mental hospital population increased 18% over the previous year, FY 1982-1983. Assuming that our current average expenditure of $166 per patient day in a state hospital provided adequate care, if Pennsylvania's average daily state mental hospital population increased by 18% over current levels, the added costs of state hospital care alone would increase by over $85 million. (12)

In the second year following Arizona's loosening of commitment statutes, the average daily state mental hospital population increased 30% over the year before the law change. Following the above assumptions for Pennsylvania, the costs of state hospital care would soar by over $141 million over our current state hospital budget. That is more than the total state appropriation for Pennsylvania community mental health services, which is $138,940,000 for FY 1987-88.

The disastrous effect which broadening commitment laws has had on Washington state has been thoroughly studied. (13)

PENNSYLVANIANS CAN IMPROVE OUR PRESENT SYSTEM

The annual cost per person in a state hospital is on the average $60,590. The Office of Mental Health approximated that about 1300 adults in the state hospital system are eligible for community rehabilitation residences. (14) The cost of serving these persons in state hospitals is about 80 million dollars per year. At an estimated annual cost of $36,500 per person in community residential programs, the cost to house these 1300 state hospital residents more appropriately in community rehabilitation residences would be about $47,450,000. This would mean an annual savings of over $32 million.

Clearly, an expansion of community mental health care systems will humanize Pennsylvania's public mental health care, and at the same time utilize government funds more efficiently. We are not calling for the closing of all state mental hospitals. Clearly there is a place for them in our present system.

But also we do not advocate maintaining the status quo. Our public mental health system is in appalling shape at present.

Of all the mental health systems found in the United States, the systems practiced in two counties tend to gain more praise than any others: Dane County, Wisconsin, and Rockland County, New York. These two county systems provide remarkably progressive models for mental health care.

In Rockland County, community public mental health services serve over 10,000 patients annually. And yet, over the last twelve years Rockland County has been forced to transfer only about one or two persons a year to state mental hospitals. (15)

Thus, in Rockland County, there is a much greater continuity of care delivered to mentally ill persons. They are not shuffled between psychiatric wards in local hospitals and then to state hospitals, as happens so frequently in Pennsylvania, as happened to the young women responsible for the 1985 incident in Pennsylvania.

These counties also emphasize innovative programs such as sophisticated crisis intervention services, which include mobile outreach teams. The mentally disturbed woman in Delaware county who finally resorted to violence, repeated called crisis hotlines for help. But no help came, because mobile outreach services are virtually non-existent in Pennsylvania.

Thus, if we adopted Rockland and Dane Counties' initiatives of caring for mentally ill persons in community settings, we would make more efficient use of taxpayers' dollars and at the same time, deliver more effective and humane services to the mentally ill of the Commonwealth.

If we had effective mobile crisis intervention teams in Philadelphia we would be able to prevent some of the appalling sights which can be viewed any winter evening at Philadelphia County's adult emergency service center.

The Task Force had an opportunity to pursue lofty, but achievable goals, to thrust Pennsylvania into a progressive new era of mental health care by seeking out innovate effective programs and setting up demonstration projects to test their applicability to our Commonwealth.

Sadly, this Task Force failed to explore these exciting possibilities.

The majority seeks a broadening of commitment statutes as if this legislation were some "magic bullet," which, once fired, will alleviate the problems beseiging Pennsylvania's public mental health care system. Today, the Task Force loaded this costly ammunition. We hope that the General Assembly perceives, before it is too late, that this magic bullet is aimed right between our own eyes.

LEGISLATION WHICH CAN IMPROVE OUR MENTAL HEALTH SYSTEM

We emphasize that state government must engage in a more thoughtful and thorough study of how we can improve public mental health care in the Commonwealth.

But we can take a few steps in the right direction, if the General Assembly will adopt the following three pieces of pending legislation.

H.B. 585 (Introduced by Rep. Wambach) which provides for Medical Assistance payments for nonhospital alcohol and drug detoxification and treatment. (Currently, Medical Assistance benefits cover only inpatient treatment.) Its companion bill, S.B. 415 has passed in the Senate.

H.B. 1351 (Introduced by Rep. Dawida) which increases state reimbursements for community rehabilitation residences.

H.B. 1143 (Introduced by Rep. Sweet) which transfers liability from the counties to the state, to pay for the inpatient treatment of criminals doing state time, who are transferred from a prison to a state psychiatric hospital.

For further information on these bills we recommend consulting their prime sponsors.

FOOTNOTES

1. Bernard L. Diamond, "The Psychiatric Prediction of Dangerousness," University of Pennsylvania Law Review, Vol. 123:439,(1974) p. 444.
2. From "Report to the Secretary of Welfare from the Blue Ribbon Committee established to review the Clinical and Patient Care Programs at Philadelphia State Hospital," Sept. 1, 1987, p. 15.
3. Ibid. p. 19.
4. Ibid. pp.2-3.
5. Richard Surles and Martin McGurrin, "Increased Use of Psychiatric Emergency Services by Young Chronic Mentally Ill Patients," Hospital & Community Psychiatry, Vol. 38, No. 4, April, 1987, p. 403.
6. Ibid. p. 404.
7. Testimony of Richard C. Surles, Administrator, Philadelphia Office of Mental Health/Mental Retardation, Department of Public Health, before Health, Human Services and Recreation Committee, Philadelphia City Council, March 3, 1986.
8. Source: Greene, Witkin, Atay, Fell and Manderschied, State and County Mental hospitals, United States, 1982-1983 and 1983-1984,and National Insitute of Mental Health, Statistical Note No. 176, July 1986, Table 6. The civilian population data used are from the National Association of State Mental Health Program Directors, Updated Final Report, Funding Sources and Expenditures of State Mental Health Agencies, figure 25.
9. Source: E. Fuller Torrey, and Sidney Wolfe, Care of the Seriously Mentally Ill: A Rating of State Programs, Washington, D.C.: Public citizen Health Research Group, 1986, Table 1.
10. Conversations with officials in the Department of Public Welfare, including Jerry Koppelman, Director of Policy, Planning and Program Development, Office of Mental Health, Pennsylvania Department of Public Welfare.
11. Ten percent of 7800 is 780. Multiply 780 x $60,590/year = $47,260,200/year.
12. Eighteen percent of 7800 is 1404. Multiply 1404 x $60,590/year = $85,068,360.
13. The most thorough review is Mary Durham and John LaFond's "The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment," Yale Law & Policy Review, Vol. III, No. 2.
14. Pennsylvania 1986-89 Health Plan, Chapter 4.
15. Conversation with Dr. Bert Pepper on 2/16/87. Dr. Pepper is the Director of Mental Health Services for Rockland County, NY.

VI. Source Notes and Comments

The source for each section of the Code is set forth below. Comments are added where the provision is other than an edited reenactment of existing law. Comments are also used to direct attention to relevant uncodified statutory provisions.

As used in these source notes and comments, MH/MR Act of 1966 refers to the act of October 20, 1966 (3rd Sp. Sess. P.L.96, No.6), known as the Mental Health and Mental Retardation Act of 1966 and MHPA refers to the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act.

Omissions of subsections or significant smaller units are explained in the comment to the section in which the omitted material would otherwise appear. Where sections or acts were repealed and not included in the Code, the references to the prior act and the explanation are provided in the disposition table.

PART I. GENERAL PROVISIONS

CHAPTER 1. PRELIMINARY PROVISIONS

SUBCHAPTER A. GENERAL

Section 101. Short title of title

Source: New.

Section 102. Definitions

Source: Section 102 of the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966" (hereinafter MH/MR Act of 1966) (50 P.S. § 4102). "Facility" incorporates the definition found in section 103 of the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act (hereinafter MHPA) (50 P.S. § 7103).

Comment: The definitions of "aftercare," "inpatient services," "outpatient services" and "partial hospitalization" have been removed from this section of the source and included in the list of powers and duties of county programs found in section 501. The definitions of "physician," and "psychologist" have been deleted as they are already provided for in their respective licensing statutes. The definition of "psychiatrist" is retained, as although they are licensed as physicians, the licensing statute does not define "psychiatrists." The definition of "social worker" is retained, as the licensing statute specifically exempts Commonwealth employees from its provisions.

The Mental Health Procedures Act of 1976 repealed the definition of "mental disability" insofar as it relates to mental illness. This definition is restored in order to clarify which mentally ill persons are qualified to receive services. See 55 Pa. Code § 5100.2 for a definition of mental illness.

Section 103. Applicability of title to the Mental Health and Mental Retardation Act of 1966

Source: New.

Comment: The provisions of the Mental Health and Mental Retardation Act of 1966 were originally intended to provide a comprehensive system for the coordinated delivery of mental health and mental retardation services at the State and county level. However, during the early 1970s, several provisions of article IV of the act relating to voluntary and involuntary admissions and commitments were declared unconstitutional. See Dixon v. Attorney General of Commonwealth of Pa., 325 F.Supp. 966 (M.D. Pa. 1971), Commonwealth ex rel. Finken v. Roop, 234

Pa. Superior Ct. 155, 339 A.2d 764, cert. denied 424 U.S. 960 (1975) and Goldy v. Beal, 429 F.Supp. 640 (M.D. Pa. 1976).

In 1976, the Mental Health Procedures Act was enacted to address the issues regarding the mentally ill raised in the court cases; it repealed many of the provisions of article IV of the 1966 act except insofar as they related to mental retardation or mentally retarded persons.

Those provisions of the 1966 act that are applicable to both mentally retarded and mentally ill persons are included in this Code, and the 1966 act provisions are repealed. Those provisions that relate solely to mentally retarded persons are saved from repeal pending their later inclusion in this Code. Many of those provisions have been found to be unconstitutional in whole or in part so that admissions and commitments of mentally retarded persons under current law are governed by a combination of the 1966 act, case law and regulations of the Department of Public Welfare.

SUBCHAPTER B. RECORDS AND IMMUNITIES

Section 111. Records

Source: Section 602(a)-(c) of the MH/MR Act of 1966 (50 P.S. § 4602(a)-(c)).

Section 112. Confidentiality of records

Source: Subsection (a) derived from section 602(d) of the MH/MR Act of 1966 (50 P.S. § 4602(d)); paragraphs (b)(1)-(4), (6) and (7) and the introduction to subsection (c) derived from section 111 of the MHPA (50 P.S. § 7111); paragraphs (b)(5) and (c)(1) through (c)(5) are new.

Comment: Paragraph (b)(3) expands court access to records to certain criminal proceedings. Paragraphs (c)(1) and (2) authorize the release of information to family and household members of patients in certain situations. Paragraph (c)(4) authorizes release of information in emergency situations when law enforcement personnel request it. Paragraphs (c)(5) and (6) authorize treatment personnel to issue warnings when believed necessary, and are intended to respond to concerns raised by Tarasoff v. Regents of the University of California, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). But see Leedy v. Hartnett, 510 F.Supp. 1125 (M.D. Pa. 1981), affirmed 676 F.2d 686 (3rd Cir. 1982).

The exceptions to the right of privileged communications in subsection (c) are not intended to affect the immunity granted under § 113, infra.

Section 113. Immunities

Source: Subsection (a) derived from section 603 of the MH/MR Act of 1966 (50 P.S. § 4603) and section 114(a) of the MHPA (50 P.S. § 7114(a)); subsection (b) derived from section 114(b) of the MHPA (50 P.S. § 7114(b)).

Comment: The sections codified in this section were specifically saved from repeal by the act of September 28, 1978 (P.L.788, No.152), referred to as the Sovereign Immunity Act of 1978. It is intended that the immunity granted by this section shall continue as an exception to the general waiver of sovereign immunity as to "acts of health care employees of Commonwealth agency medical facilities or institutions or by a Commonwealth party who is a doctor, dentist, nurse or related health care personnel." 42 Pa.C.S. § 8522(b)(2).

SUBCHAPTER C. FINANCIAL OBLIGATIONS

Section 121. Liability of mentally disabled person

Source: Section 501 of the MH/MR Act of 1966 (50 P.S. § 4501).

Section 122. Liability of persons owing legal duty to support

Source: Section 502 of the MH/MR Act of 1966 (50 P.S. § 4502).

Comment: As to which funds of a patient are available to meet the liability imposed by this section and section 121, see Lang v. Com., Dept. of Public Welfare, 528 A.2d 1335 (Pa. 1987).

Section 123. Contingent liability of State and local government

Source: Section 503 of the MH/MR Act of 1966 (50 P.S. § 4503).

Section 124. Powers of department to determine liability and establish criteria

Source: Section 504 of the MH/MR Act of 1966 (50 P.S. § 4504).

Section 125. Liability of county

Source: Subsections (a), (c) and (d) derived from section 505(a), (b) and (c) of the MH/MR Act of 1966 (50 P.S. § 4505(a)-(c)); subsection (b) derived from section 408 of the MHPA (50 P.S. § 7408).

Section 126. Collection of costs

Source: Section 506 of the MH/MR Act of 1966 (50 P.S. § 4506).

Section 127. Liability of Commonwealth

Source: Paragraphs (1) through (4) derived from section 507 of the MH/MR Act of 1966 (50 P.S. § 4507); paragraphs (5) and (6) are new. Reference to the Public Assistance Law in section 507(3) of the source is replaced with a reference to the Public Welfare Code as the former statute was repealed by the latter.

Comment: The amendment to paragraph (3) specifies benefit periods for different types of partial hospitalization. Also in paragraph (3), inpatient mental health benefits are removed from 100 percent Commonwealth funding and made subject to the 90 percent Commonwealth, 10 percent county funding allocation required in section 129. Residential services are authorized at the 100 percent funding level in paragraph (5) to de-emphasize inpatient services and emphasize community care for mentally ill persons.

Section 128. Relief of county from obligation to ensure service

Source: Section 508 of the MH/MR Act of 1966 (50 P.S. § 4508).

Section 129. State and local grants and payments

Source: Section 509 of the MH/MR Act of 1966 (50 P.S. § 4509).

Comment: The last sentence of paragraph (1) is added to encourage charitable donations to county programs.

Section 130. Failure of county program to comply with minimum standards

Source: Subsections (a), (b) and (c) derived from section 512(c), (d) and (e) of the MH/MR Act of 1966 (50 P.S. § 4512(c), (d) and (e)).

Comment: Subsections (a) and (b) of section 512 have been omitted as transitional.

CHAPTER 3. DEPARTMENT OF PUBLIC WELFARE

SUBCHAPTER A. GENERAL PROVISIONS

Section 301. General powers and duties of department

Source: Paragraphs (1)-(5), (7) and (8) derived from section 201(1)-(5), (7) and (8) of the MH/MR Act of 1966 (50 P.S. § 4201(1)-(5), (7) and (8)); paragraphs (9) and (10) derived from section 202(a) and (b) of the MH/MR Act of 1966 (50 P.S. § 4202(a) and (b)); paragraphs (11) and (12) derived respectively from section 2313(a) and (b) of the act of April 9, 1929 (P.L.177, No.175), known as the Administrative Code of 1929 (71 P.S. § 603(a) and (b)); paragraphs (6) and (13) through (15) are new.

Comment: For provisions governing regulatory procedures, see the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act (71 P.S. § 745.1 et seq.), the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act (71 P.S. § 732-101 et seq.), Title 45 Pa.C.S. (relating to legal notices) and the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law (45 P.S. § 1102 et seq.). The amendments to paragraph (9) are intended to encourage State hospitals to become involved in maintaining continuity of care for patients, and require State hospitals to meet standard levels of care.

Section 302. Commissioner of Mental Health

Source: Act of July 9, 1987 (P.L.207, No.32).

Section 303. Bureau of Admissions Services

Source: New.

Comment: The creation of this bureau is intended to aid in the coordination of admissions services, the supervision of services to persons in State or local correctional institutions and training of personnel involved in the commitment process.

Section 304. Qualifications of directors of State facilities

Source: Section 203 of the MH/MR Act of 1966 (50 P.S. § 4203).

Section 305. Forms to be used under this title

Source: Section 601 of the MH/MR Act of 1966 (50 P.S. § 4601).

SUBCHAPTER B. DEPARTMENTAL BOARDS AND COMMITTEES

Section 311. Boards of trustees of State institutions

Source: Subsections (a) through (d) derived from section 401 of The Administrative Code of 1929 (71 P.S. § 111); subsection (e) derived from subsection 317(a) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code (62 P.S. § 317(a)). The names of the State mental retardation centers are found in 1986-87 Governor's Executive Budget, Commonwealth of Pennsylvania, p. 695.

Section 312. Advisory Committee for Mental Health and Mental Retardation

Source: Subsections (a) through (d) derived from section 448(k) and (l) of the Administrative Code of 1929 (71 P.S. § 158(k) and (l)); (e)(1)-(4) derived from section 2328 of the Administrative Code of 1929 (71 P.S. § 611.8); (e)(5) derived from § 301(c) of the MH/MR Act of 1966 (50 P.S. § 4301(c)).

Comment: The provision requiring that recommendations be made to the State Board of Public Welfare is omitted, as the board was terminated on June 30, 1986 under § 6(a) of the act of December 22, 1981 (P.L.508, No.142), known as the Sunset Act.

Section 313. Conjoint Board

Source: New.

Comment: This section is intended to establish regional boards that encourage and facilitate joint planning between State hospitals and the communities they serve.

CHAPTER 5. COUNTY BOARDS OF MENTAL HEALTH AND MENTAL RETARDATION

Section 501. General powers and duties of local authorities

Source: Subsection (a) derived from section 301(a) and (b) of the MH/MR Act of 1966 (50 P.S. § 4301(a) and (b)); subsections (b), (c)(1)-(9), (d) and (e) derived respectively from section 301(c) through (f) of the MH/MR Act of 1966 (50 P.S. § 4301(c) through (f)); paragraphs (c)(10)-(13) are new.

Comment: The amendment to (c)(2) is a clarifying amendment. The amendment to paragraph (c)(3) specifies the types of partial hospitalization service to be provided. The types of services listed in (c)(1), (2), (3) and (6) were included in the definitions of these terms found in section 102 of the MH/MR Act of 1966. References to "classification" were deleted from these definitions as unnecessary. The amendments to paragraphs (c)(5), (6) and (7) remove further definition of these services, as they are sometimes interpreted to limit services to the ones enumerated in those paragraphs. Case management services are mandated in paragraphs (c)(10) and (11) to ensure continuity of care for persons moving through the mental health system. Residential services are mandated in (c)(12). Training is changed from an optional service to a mandated service in (c)(13) and complements the amendment to section 301(6). Training will be funded at the 100 percent Commonwealth funding level (see § 127(6)).

Section 502. County mental health and mental retardation board

Source: Section 302 of the MH/MR Act of 1966 (50 P.S. § 4302).

Section 503. Duties of board

Source: Section 303 of the MH/MR Act of 1966 (50 P.S. § 4303).

Section 504. Appointment of county mental health and mental retardation administrator

Source: Section 304 of the MH/MR Act of 1966 (50 P.S. § 4304).

Section 505. Duties of the administrator

Source: Section 305 of the MH/MR Act of 1966 (50 P.S. § 4305).

CHAPTER 7. RESEARCH AND TRAINING

SUBCHAPTER A. EASTERN PENNSYLVANIA PSYCHIATRIC INSTITUTE

Section 701. Purpose

Source: Section 1 of the act of April 18, 1949 (P.L.599, No.126) (50 P.S. § 581).

Section 702. Contracts with medical schools

Source: Section 1 of the act of April 18, 1949 (P.L.599, No.126) (50 P.S. § 581).

Section 703. Leases

Source: Section 3.1 of the act of April 18, 1949 (P.L.599, No.126) (50 P.S. § 583.1).

SUBCHAPTER B. WESTERN STATE PSYCHIATRIC INSTITUTE AND CLINIC

Section 711. Purpose

Source: Section 1 of the act of May 20, 1949 (P.L.1643, No.496) (50 P.S. § 575.1).

Section 712. Management

Source: Section 2 of the act of May 20, 1949 (P.L.1643, No.496) (50 P.S. § 575.2).

Section 713. Medical advisory board

Source: Subsections (a) and (b) derived from section 3 of the act of May 20, 1949 (P.L.1643, No.496) (50 P.S. § 575.3); subsection (c) derived from section 4 of the act (50 P.S. § 575.4).

Section 714. Leases

Source: Subsections (a), (b) and (c) derived respectively from sections 5, 6 and 7 of the act of May 20, 1949 (P.L.1643, No.496) (50 P.S. §§ 575.5, 575.6 and 575.7).

PART II. MENTAL HEALTH

CHAPTER 9. GENERAL PROVISIONS

SUBCHAPTER A. PRELIMINARY PROVISIONS

Section 901. Short title of part

Source: Section 101 of the MHPA (50 P.S. § 7101).

Section 902. Statement of policy

Source: Section 102 of the MHPA (50 P.S. § 7102).

Comment: The change from "adequate" treatment to treatment "appropriate to the individual's needs" is intended to ensure that the least restrictions required for treatment are individually determined. The last three sentences of the source section are deleted as transitional.

Section 903. Scope of part

Source: The first and second sentences of section 103 of the MHPA (50 P.S. § 7103).

SUBCHAPTER B. GENERAL TREATMENT PROVISIONS

Section 911. Provision for treatment

Source: Section 104 of the MHPA (50 P.S. § 7104).

Section 912. Treatment facilities

Source: Section 105 of the MHPA (50 P.S. § 7105).

Section 913. Formulation and review of treatment plan

Source: Subsections (a) through (d) derived from section 106 of the MHPA (50 P.S. § 7106); subsections (e) and (f) derived from section 107 of the MHPA (50 P.S. § 7107).

Section 914. Periodic reexamination, review and redisposition

Source: Section 108 of the MHPA (50 P.S. § 7108).

Section 915. Rights and remedies of persons in treatment

Source: Section 113 of the MHPA (50 P.S. § 7113).

Section 916. Continuity of care

Source: Section 116 of the MHPA (50 P.S. § 7116).

Comment: The amendments to this section are intended to ensure that all persons receiving publicly funded inpatient mental health services receive referrals to county programs upon discharge; prior law only required such referrals upon discharge from State mental hospitals.

Section 917. Medical necessity of treatment

Source: Subsection 206(c) of the MHPA (50 P.S. § 7206(c)).

SUBCHAPTER C. JUDICIAL MATTERS

Section 921. Mental health review officers

Source: Subsections (a), (c) and (d) derived from section 109(a) through (c) of the MHPA (50 P.S. § 7109(a)-(c)); subsection (b) is new.

Comment: The last sentence of subsection (a) is added to ensure that a certification by a mental health review officer is treated as a final order, subject to appeal, thereby expediting the availability of an appeal by either party to the court as provided in subsection (c). This will avoid the situation where an individual's status is unclear pending

judicial approval of the review officer's certification. This reverses the rule set forth in In re Chambers, 282 Pa. Superior Ct. 327, 422 A.2d 1140 (1979).

Section 922. Documents

Source: Section 110 of the MHPA (50 P.S. § 7110).

Section 923. Jurisdiction of legal proceedings

Source: Subsections (a) and (b) derived from section 115(a) of the MHPA (50 P.S. § 7115(a)). Subsection 115(b) is omitted as unnecessary.

CHAPTER 11. VOLUNTARY EXAMINATION AND TREATMENT

Section 1101. Persons who may authorize voluntary treatment

Source: Section 201 of the MHPA (50 P.S. § 7201).

Section 1102. Application

Source: Section 202 of the MHPA (50 P.S. § 7202).

Section 1103. Explanation and consent

Source: Section 203 of the MHPA (50 P.S. § 7203).

Section 1104. Notice to parents

Source: Section 204 of the MHPA (50 P.S. § 7204).

Section 1105. Physical examination and treatment plan

Source: Section 205 of the MHPA (50 P.S. § 7205).

Section 1106. Withdrawal from voluntary inpatient treatment

Source: Section 206(a) of the MHPA (50 P.S. § 7206(a)).

Section 1107. Release of persons 13 years of age or younger

Source: Section 206(b) of the MHPA (50 P.S. § 7206(b)).

Comment: For rules governing juvenile proceedings, see the Juvenile Act, 42 Pa.C.S. Ch. 63.

Section 1108. Transfer of person in voluntary treatment

Source: Section 207 of the MHPA (50 P.S. § 7207).

CHAPTER 13. INVOLUNTARY EXAMINATION AND TREATMENT

Section 1301. Persons who may be subject to involuntary emergency examination and treatment

Source: Subsections (a), (b) and (c) derived respectively from subsections 301(a), (b)(1) and (b)(2) of the MHPA (50 P.S. § 7301(a), (b)(1) and (b)(2)); subsection (d) derived from the last sentences of subsections 301(b)(1), (b)(2)(ii) and (b)(2)(iii) of the MHPA (50 P.S. § 7301(b)(1), (b)(2)(ii) and (b)(2)(iii)).

Comment: This section has been amended to add substantial property damage to the determination of a clear and present danger of harm to others. The last sentence of subsection (a) is added to ensure that past behavior and medical history are treated as relevant evidence in involuntary proceedings.

The time period during which behavior may be considered has been extended from 30 to 60 days. The 60-day limitation is to be tolled during any period of criminal detention, in addition to whenever a person is found incompetent to be tried or acquitted by reason of lack of criminal responsibility.

Attempts to inflict "serious bodily harm" in the determination of danger to others is changed to bodily harm. The determination of harm to self based upon the "inability to care" standard has been amended to remove death or serious bodily harm to permit earlier intervention. A definition of "bodily injury" can be found at 18 Pa.C.S. § 2301 (relating to definitions). Subsection (d) would permit a commitment based on dangerousness if a person threatened to commit acts and the person's past behavior (including medical history) indicates a likelihood that the threats will be carried out; to this extent, an "overt act" is not required.

Section 1302. Involuntary emergency examination and treatment not to exceed five business days

Source: Subsection (a) derived from the first sentence of subsection 302(a) of the MHPA (50 P.S. § 7302(a)); subsections (b), (c) and (d) derived respectively from paragraphs 302(a)(1), (a)(2) and (b) of the MHPA (50 P.S. § 7302(a)(1), (a)(2) and (b)); (e) derived from the first three sentences of subsection 302(c) of the MHPA (50 P.S. § 7302(c)); (f) derived from the last sentence of subsection 302(c) of the MHPA (50 P.S. § 7302(c)); (g) derived from subsection 302(d) of the MHPA (50 P.S. § 7302(d)); (h) is new.

Comment: This section is amended by increasing the maximum time period for emergency treatment from 120 hours to five business days. The last sentence of subsection (g) is added to complement the provisions of section 1307.

The amendment adding psychologists to the group of persons authorized to effect an examination under this section is intended to authorize licensed, doctoral-level psychologists so to act.

Subsection (c) is amended to authorize emergency examination without a warrant upon statements made by a person believed to be severely mentally disabled and in need of treatment.

The language authorizing notice to police of the pending release of persons in certain circumstances is intended to assist police in regaining custody of persons who are believed to have committed criminal acts.

For a definition of peace officer, see 18 Pa.C.S. § 501.

Section 1303. Extended involuntary emergency treatment not to exceed 20 days

Source: Subsections (a)-(f) derived respectively from section 303(a)-(f) of the MHPA (50 P.S. § 7303(a)-(f)); subsection (g) derived from section 303(h) of the MHPA (50 P.S. § 7303(h)).

Comment: Subsection 303(g) of the MHPA has been deleted as unnecessary, as it is provided in § 921(c) of this code.

Section 1304. Court-ordered involuntary treatment not to exceed 90 days

Source: Paragraphs (a)(1) through (a)(7) derived respectively from section 304(b)(1), (b)(2) (first sentence), (a)(2), (b)(2) (second and third sentences), (b)(3), (b)(4) and (b)(5) of the MHPA (50 P.S. § 7304(b)(1), (b)(2) (first sentence), (a)(2), (b)(2) (second and third sentences), (b)(3), (b)(4) and (b)(5)); subsections (b) and (c) derived respectively from section 304(c) and (d) of the MHPA (50 P.S. § 7304(c) and (d)); paragraphs (d)(1) through (d)(5) derived respectively from section 304(e)(2) and (3), (e)(4), (e)(5), (e)(6) and (e)(7) of the MHPA (50 P.S. § 7304(e)(2) and (3), (e)(4), (e)(5), (e)(6) and (e)(7)); subsections (e) and (f) derived respectively from section 304(f) and (g)(1) of the MHPA (50 P.S. § 7304(f) and (g)(1)); paragraphs (g)(1) through (g)(3) derived respectively from section 304(g)(2) through (g)(4) of the MHPA (50 P.S. § 7304(g)(2) through (g)(4)); (h) derived from section 305(b) of the MHPA (50 P.S. § 7305(b)).

Note: The provisions of section 304(e)(1) and (e)(6) of the source have been deleted, as they are provided for, in the case of (e)(1), in section 1304(a)(5) and (b)(4), and in the case of (e)(6), in section 921(a). The provisions of subsection 1304(f) have been structured to parallel the provisions regarding duration of treatment found in sections 1302(g) and 1303(h) and to incorporate the treatment options authorized in sections 1106 and 1305.

Comment: Under current law, only arson under 18 Pa.C.S. § 3301 is an act that would require detention of a severely mentally disabled person in treatment for a period of one year under subsection (g). This amendment would add the related offenses of arson, endangering persons or property and reckless burning or exploding. Additionally, attempts to commit any of the acts enumerated in (g)(1) can subject a person to court-ordered involuntary treatment for up to one year.

Section 1305. Additional periods of court-ordered involuntary treatment

Source: Subsections (a) through (d) derived from section 305(a) of the MHPA (50 P.S. § 7305(a)); subsection (e) derived from section 305(b) of the MHPA (50 P.S. § 7305(b)).

Comment: Language referring to a showing of conduct during the person's most recent period of court-ordered treatment has been deleted from subsection (b) as it has been interpreted to require a recurrence of behavior as defined in section 1301, although its original intent was to simply require some evidence of a continuing need for treatment.

Section 1306. Transfer of persons in involuntary treatment

Source: Subsections (a)-(c) derived from section 306 of the MHPA (50 P.S. § 7306); (d) is new.

Comment: The last sentence of subsection (c) and all of subsection (d) are added to assist in implementing section 1307.

Section 1307. Court-ordered involuntary outpatient treatment procedures

Source: New.

Comment: Although outpatient treatment is currently authorized under the MHPA, it is a general authorization. The provisions of this section are intended to establish procedures for outpatient treatment and provide an enforcement mechanism.

Treatment authorized in this section is intended to supply an additional treatment option under section 1304 or 1305. See also section 1302(g).

CHAPTER 15. EXAMINATION AND TREATMENT OF PERSONS CHARGED WITH CRIME OR UNDER SENTENCE

Section 1501. Examination and treatment

Source: Subsection (a) derived from section 401(a) of the MHPA (50 P.S. § 7401(a)); subsection (b) derived from the first three sentences of section 401(b) of the MHPA (50 P.S. § 7401(b)); subsection (c) derived from last sentence of section 401(a) and the fourth and fifth sentences of section 401(b) of the MHPA (50 P.S. § 7401(a) and (b)); subsections (d) and (e) derived respectively from the penultimate and ultimate sentences of section 401(b) of the MHPA (50 P.S. § 7401(b)).

Comment: The exception in subsection (a) is added to facilitate treatment of persons charged with a crime or undergoing sentence by allowing a 90-day treatment period for a person subject to a 5-day treatment period under section 1302 without requiring an intervening 20-day treatment period under section 1303.

Section 1502. Incompetence to proceed on criminal charges

Source: Subsections (a), (b), (c), (d), (h) and (i) derived respectively from section 402(a), (b), (c), (d), (f) and (g) of the MHPA (50 P.S. § 7402(a)-(d), (f) and (g)); subsection (e) derived from section 402(e)(1) through (3) of the MHPA (50 P.S. § 7402(e)(1) through (3)); subsection (f) derived from section 402(e)(4)(i) and (ii) of the MHPA (50 P.S. § 7402(e)(4)(i) and (ii)); subsection (g) derived from section 402(e)(4)(iii) and (iv) of the MHPA (50 P.S. § 7402(e)(4)(iii) and (iv)).

Section 1503. Hearing and determination of incompetency to proceed

Source: Section 403 of the MHPA (50 P.S. § 7403).

Section 1504. Hearing and determination of criminal responsibility

Source: Section 404 of the MHPA (50 P.S. § 7404).

Section 1505. Examination of person charged with crime as aid in sentencing

Source: Section 405 of the MHPA (50 P.S. § 7405).

Section 1506. Civil procedure for court-ordered involuntary treatment

Source: Section 406 of the MHPA (50 P.S. § 7406).

Section 1507. Voluntary treatment

Source: Subsections (a), (b), (d), (e) and (f) derived respectively from section 407(a), (b), (d), (e) and (f) of the MHPA (50 P.S. § 7407(a), (b), (d), (e) and (f)); subsection (c) derived from section 407(c) of the MHPA (50 P.S. § 7407(c)) and section 331 of the act of October 5, 1980 (P.L.693, No.142), known as the JARA Continuation Act of 1980 (42 P.S. § 20041).

PART III. MENTAL RETARDATION

(RESERVED)

PART IV. SPECIAL PROVISIONS RELATING TO PATIENTS

CHAPTER 23. GENERAL PROVISIONS

Section 2301. Powers and duties of director of facility

Source: Section 417 of the MH/MR Act of 1966 (50 P.S. § 4417).

Section 2302. Transportation

Source: Section 421 of the MH/MR Act of 1966 (50 P.S. § 4421).

Note: Reference to persons "of the same sex" deleted, as this section was repealed insofar as inconsistent with the act of October 4, 1978 (P.L.909, No.173), which implemented the equal rights amendment to the Constitution of Pennsylvania.

Section 2303. Mechanical restraints

Source: Subsections (a) and (b) derived respectively from section 422(1) and (2) of the MH/MR Act of 1966 (50 P.S. § 4422 (1) and (2)).

Section 2304. Patients rights

Source: Subsection (a) derived from section 423 of the MH/MR Act of 1966 (50 P.S. § 4423); subsections (b), (c) and (d) are new.

Section 2305. Escapes

Source: Subsections (a), (b) and (c) derived from section 425(a), (b) and (c) of the MH/MR Act of 1966 (50 P.S. § 4425(a), (b) and (c)); (d) derived from section 425(d) and (e) of the MH/MR Act of 1966 (50 P.S. § 4425(d) and (e)).

Section 2306. Penalties

Source: Section 605 of the MH/MR Act of 1966 (50 P.S. § 4605).

Section 2307. Funds of patients

Source: New.

Comment: Section 424 (Funds of Persons Admitted or Committed to State Operated Facilities) of the MH/MR Act of 1966 was declared unconstitutional by the Federal Court for the Eastern District of Pennsylvania in Vecchione v. Wohlgemuth, 377 F.Supp. 1361 (E.D. Pa. 1974), 426 F.Supp. 1297 (1977), 558 F.2d 150 (1977), cert. denied 434 U.S. 943 (1977), 80 F.R.D. 32 (1978), 481 F.Supp. 776 (1979). As a result of that decision, the Department of Public Welfare implemented regulations to establish the powers and duties of Guardian Offices at all State mental health hospitals and mental retardation centers (55 Pa. Code Chapter 11). This section is meant to complement those regulations.

PART V. INTERSTATE RELATIONS

CHAPTER 25. INTERSTATE COMPACT ON MENTAL HEALTH

Section 2501. Compact provisions

Source: Section 1121 the Public Welfare Code (62 P.S. § 1121).

Section 2502. Compact administrator

Source: Section 1122 of the Public Welfare Code (62 P.S. § 1122).

Section 2503. Supplementary agreements

Source: Section 1123 of the Public Welfare Code (62 P.S. § 1123).

Section 2504. Financial obligations

Source: Section 1124 of the Public Welfare Code (62 P.S. § 1124).

Section 2505. Consultation with families of transferees

Source: Section 1125 of the Public Welfare Code (62 P.S. § 1125).

Section 2506. Limitation of compact applicability

Source: Section 1126 of the Public Welfare Code (62 P.S. § 1126).

Section 2507. Commitment or transfers to facilities of Federal Government or of another state

Source: Section 415 of the MH/MR Act of 1966 (50 P.S. § 4415).

CHAPTER 27. RECIPROCAL AGREEMENTS WITH OTHER STATES

Section 2701. Agreements authorized

Source: Section 1131 of the Public Welfare Code (61 P.S. § 1131).

Section 2702. Deportations

Source: Section 414 of the MH/MR Act of 1966 (50 P.S. § 4414).

Appendix A. Table of Witnesses

PUBLIC HEARING, JULY 8, 1986, PITTSBURGH

Honorable W. Louis Coppersmith

Jud Trax, consumer of mental health services

Eleanor B. Slater, co-founder, Pittsburgh Alliance for the Mentally Ill

Reverend John Rickloff, president, United Mental Health, Inc.

Marjorie A. Kerns, president, Beaver County Alliance for the Mentally Ill

Mary Kay Russo, executive director, Beaver County Mental Health Society

Dr. Robert M. Wettstein, assistant professor of psychiatry, Western Psychiatric Institute and Clinic

Muriel Weeks, executive director, Mental Health Association in Westmoreland County

Kathalyn O'Brien, chairman, REACH (Families of Mentally Ill)

E. Edward Sheldon, vice president, ADMIT (Advocates for the Mentally Ill in Transition)

Sherry Harbaugh, member, Government Affairs Committee, Mental Health Association in Butler County

Gary R. Lucht, warden, Erie County Prison

Lynne M. Loresch, executive director, Washington County Mental Health Association

Sister Helen Elizabeth McElwain, administrative assistant, St. Joseph's House of Hospitality

Noma Shaw, chair, SHAPP (Self-Help Alliance of Psychiatric Patients)

Kathleen Hintenach, consumer of mental health services

Patricia Taha, R.N., psychiatric nurse supervisor, Woodville State Hospital

Judith Marker, executive director, East End Cooperative Ministry

Robina Linear King, Peoples Oakland Mental Health Project

Ron Gibson, Peoples Oakland Mental Health Project

Raymond R. Webb Jr., executive director, Allegheny East Mental Health/ Mental Retardation Center, Inc.

PUBLIC HEARING, JULY 29, 1986, ALTOONA

Dadrea J. Davis, adult protective service worker, Westmoreland County Area Agency on Aging

Marta Peck, executive director, Mental Health Association of York County

Sharyn Funderwhite, consumer of mental health services

Thomas Ferguson, Pennsylvania Nurses Association

Sergeant Thomas P. Semelsberger, Pennsylvania State Police

Darrell Nixdorf, administrator, Blair County Mental Health/ Mental Retardation Program (on behalf of the Mental Health and Mental Retardation Program Administrators Association of Pennsylvania)

Dr. Doo Wan Cho, director of the mental health center, Altoona Hospital

Drs. H. Allen Handford and Joyce D. Kales, Divisions of Child and Adolescent Psychiatry and Community Social Psychiatry, Department of Psychiatry and Central Pennsylvania Psychiatric Institute, Pennsylvania State University College of Medicine

Dr. Richard G. Lonsdorf, Pennsylvania Psychiatric Society

Ernest Podrasky, crisis center coordinator, Altoona Hospital

Dr. Donald B. Crider, psychiatrist, Altoona

Professor Daniel Katkin, program head, Administration of Justice, College of Human Development, Pennsylvania State University

Glen Comitz, family member

Dr. F. Ulus, staff psychiatrist, Community Mental Health Center, Altoona Hospital

PUBLIC HEARING, SEPTEMBER 10, 1986, MEDIA

Ruth Seegrist, family member

Pastor Robert Strain, Faith Reformed Church

Bob Boyer, consumer of mental health services

Terry Thomson, consumer of mental health services

Bill Dougherty, consumer of mental health services

Ann Marie DeAscentis, consumer of mental health services

Sherlyn Philyaw, consumer of mental health services

Richard Irwin, consumer of mental health services

Rosalie Fisher, consumer of mental health services

Gail M. Whitaker, Esq., past president, Delaware County Mental Health/Mental Retardation Board

Dr. Peter B. Bloom, director, Continuing Education in Psychiatry, The Institute of Pennsylvania Hospital

Honorable Stephen Freind, State Representative

Fred Moran, commissioner, Haverford, Delaware County

Phyllis Eroh, family member

Jacqueline, Daniel and Donald McKenna, family members

Marilyn Meisel, family member

Helen Strickland, R.N.

Joanna Christaldi, Delaware County Base Service Unit

Sally Thomas, Families United for Mental Health

Jack Meyers, family member

Denise Enderle, president, board of directors, Community Life Services, Inc.

Jane Shea, family member

PUBLIC HEARING, OCTOBER 23, 1986, PHILADELPHIA

Ron Castille, Esq., district attorney, Philadelphia County

Dr. Maurice Clifford, commissioner, Department of Public Health, City of Philadelphia

Honorable John F. White, councilman, City of Philadelphia

Lillian Whitten, family member

Sister Mary Scullion, Women of Hope

Dr. Paul J. Fink, Albert Einstein Medical Center

Robert Holmes, West Philadelphia Mental Health Consortium

Dr. Max Silverstein, Committee on Severely Chronically Mentally Ill Homeless, Mayor's Public-Private Task Force on Homelessness

Dr. Richard R. Silbert, Mercy Catholic Medical Center

Bernard Mazie, M.A., psychologist

Dr. Thora Brown, Delaware Valley Association of Black Psychologists

Hilda Robbins, consumer of mental health services

Dr. F. Lewis Bartlett, formerly at Haverford State Hospital

Dr. Marcella Lingham, Black Family Services

Roseann Hartigan, R.N., Pennsylvania Nurses Association

Jacqueline Springer, R.N., Philadelphia State Hospital

Trudy McGraw, Pennsylvania Nurses Association

Bernard Ellerkamp, R.N., Philadelphia State Hospital

Mary Ellen Rehrman, Alliance for the Mentally Ill of Eastern Pennsylvania

Ronald Comer, Philadelphia Advocates for the Mentally Disabled

Ilene W. Shane, Esq., chair, Mental Disability Committee, Philadelphia Bar Association

Maureen McCullough, Esq., chair, Committee on the Problems of the Homeless, Philadelphia Bar Association

Robert Carrozza, R.N., Mercy Catholic Medical Center

Stephen Blanchard, associate director for administration, Philhaven Hospital

PUBLIC HEARING, DECEMBER 10, 1986, SCRANTON

Raymond Colleran, warden, Lackawanna County Prison

Dr. Sara Ann Warren, vice-president, Pennsylvania Association of State Mental Hospital Physicians

Wilma Weiner, occupational therapist, formerly at Norristown State Hospital

Les Varano, family member

Dr. Clancy McKenzie, psychiatrist, Bala Cynwyd

Mary Judith Schild, family member

Michael Basista, assistant district attorney, Lackawanna County

Barbara Pilvin, consumer of mental health services

Dennis Fisher, Mental Health and Mental Retardation Meet and Discuss Committee, Pennsylvania Social Services Union

Lecie Machell for Fran Fuge, family member

Bernard Podcasy, district attorney, Luzerne County

John A. Creek, president-elect, Pennsylvania Association of Community Mental Health and Mental Retardation Providers

Susan Gilhooly, Esq., master, Chester County

Anne Ringkamp, family member

Sandra Hamzavi, board president, Scranton Counseling Center

PUBLIC HEARING, JANUARY 28, 1987, HARRISBURG

Robert Haigh, director, Office of Policy Management and Program Development, Department of Public Welfare

Dr. Mary L. Durham, director, Center for Health Studies, Group Health Cooperative of Puget Sound

Anna Berger Price, president, Pennsylvania Social Services Union

Harold DeGreen, family member

Robert Carrozza, R.N., Mercy Catholic Medical Center

Robert Sacavage, Esq., district attorney, Northumberland County

Richard Stober, director, Economic and General Welfare Program, Pennsylvania Nurses Association

Sue Davies, director, Berks County Mental Health Association

John Rattigan, consumer of mental health services

Marianne Kriner, director, Clients Rights Advocacy Project, Berks County Mental Health Association

Marie Bond, consumer of mental health services

Ida de Colon-Smith, former director, Clients Rights Advocacy Project, Berks County Mental Health Association

Dr. Margaret Pepe, professional affairs officer, Pennsylvania Psychological Association

Terry Roth, Esq., board of directors, Mental Health Association in Pennsylvania

Edward J. Keller, executive director, Council 13, AFSCME, AFL-CIO

Dr. Altha Stewart, unit director, Department of Psychiatry, Hahnemann University

May Williams, concerned citizen

Officer Harriett Farr, Philadelphia Police Department

Ann Jennings, director, Project ACCESS, Mental Health Association of Southeastern Pennsylvania

Cathy Cowan, president, Pennsylvania State Association of County Commissioners

Vivian Spiese, vice-president, Lancaster County Alliance for the Mentally Ill

Dr. Arnold Shienwold, Harrisburg Area Psychological Association

Alexander Hazzouri, executive director, Mental Health Association in Lackawanna County

STATEMENTS SUBMITTED DIRECTLY TO THE COMMISSION

Anna M. Horan, R.N.

Thomas Atkinson, employee, Farview State Hospital

Mr. and Mrs. Charles J. Netzel III, family members

Genevieve Yatsko, family member

Stephen A. Ragusea, Psy.D., clinical psychologist, State College

Jonathan E. Zimmer, executive director, ACTION-Housing, Inc.

Faye Etling, family member

Stella Montagnoli, family member

James D. Schreyer, concerned citizen

Fred W. Jacobs, chairman, Board of Probation and Parole

Marian Fromer, R.N., Eastern State School and Hospital

Dr. George S. Layne, director of mental health services, Lower Bucks Hospital

Jeanne Brince, R.N., M.S.N.

Irene Pernsley, human services commissioner, City of Philadelphia

Edward J. Kenna, family member

Sharyn Funderwhite, consumer of mental health services

Beverly Palumbo, president, Families and Friends for the Mentally Ill of Northeastern Pennsylvania

Alice A. Herzon, executive director, Philadelphia Alliance of Specialized Mental Health and Mental Retardation Agencies

Malcolm Lazin, Esq., chairman, Local Legislative Committee, Greater Philadelphia Chamber of Commerce

Sheila Stacks, chairman, Public Affairs Committee, Mental Health Association in Cumberland, Dauphin and Perry Counties

John L. Turner, member, Delaware County Chapter, Alliance for the Mentally Ill

Joselyn McLaughlin, president, Local 1966, American Federation of Government Employees

Honorable Lois Sherman Hagarty, State Representative

Dr. Steven W. Jewell, president, Pittsburgh Regional Council of Child Psychiatry

Donna Bumbarger, Economic and General Welfare Commission and Ken Chriscaden, president, Local 117, Pennsylvania Nurses Association

Eugene Wayne, president, Pennsylvania Association of Private Psychiatric Hospitals

Garold Tennis, Esq., chief of legislation, District Attorney's Office, Philadelphia County

Appendix B. Disposition Table

The following table locates the sections of the present law in the Mental Health and Mental Retardation Code. The first column shows references by act and section in the official Pennsylvania Pamphlet Laws. The second column shows the section references in Purdon's Pennsylvania Statutes Annotated; unless otherwise indicated, these references are to Title 50. The third column shows section references in the proposed Code. Where acts or parts of acts have been repealed as unnecessary or obsolete or because their provisions have been executed or supplied elsewhere, it has been noted in the third column.

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of April 4, 1831 (P.L.423, No.194)	50 P.S. §§ 561-568	Obsolete
Act of April 5, 1832 (P.L.292, No.128)	--	Executed
Act of May 8, 1855 (P.L.512, No.533)		
§ 1	--	Obsolete
§ 11	50 P.S. § 548	Obsolete
Act of February 23, 1859 (P.L.71, No.61)	--	Obsolete
Act of February 26, 1861 (P.L.49, No.55)	--	Obsolete
Act of April 22, 1863 (P.L.539, No.535)		
§ 13	50 P.S. § 541	Obsolete
§ 14	50 P.S. § 545	Obsolete
§ 19	50 P.S. § 550	Obsolete
Act of March 25, 1864 (P.L.77, No.82)	--	Obsolete
Act of April 18, 1864 (P.L.451, No.386)		
§ 1	50 P.S. § 541	Obsolete
§ 3	50 P.S. § 546	Obsolete
§ 4	50 P.S. § 547	Obsolete
Act of April 24, 1869 (P.L.90, No.66)	--	Obsolete
Act of May 7, 1874 (P.L.119, No.51)	71 P.S. § 1515	Obsolete
Act of April 27, 1876 (P.L.47, No.37)		
§ 1	--	Obsolete
§ 2	50 P.S. § 549	Obsolete

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of June 13, 1883 (P.L.92, No.86)	--	Obsolete
Act of June 10, 1897 (P.L.138, No.114)		
§ 1	50 P.S. § 707	Superseded
§ 2	Repealer	Obsolete
Act of May 15, 1903 (P.L.446, No.424)	--	Executed
Act of May 28, 1907 (P.L.292, No.222)		
§ 4	50 P.S. § 944	Superseded
Act of May 13, 1909 (P.L.533, No.294)		
§ 1	50 P.S. § 626	Obsolete
Act of June 9, 1911 (P.L.862, No.334)		
§ 1	50 P.S. § 479	Executed
§ 2	Repealer	Obsolete
Act of April 14, 1915 (P.L.120, No.54)		
§ 7	50 P.S. § 918	Superseded
Act of June 1, 1915 (P.L.661, No.293)		
§§ 1 - 8	71 P.S. § 1781 - 1788	Superseded
Act of April 6, 1921 (P.L.99, No.59)		
§ 1	50 P.S. § 797	Obsolete
§ 2	50 P.S. § 798	Obsolete
Act of May 10, 1927 (P.L.883, No.450)	50 P.S. § 325	Executed

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Administrative Code of 1929 (P.L.177, No.175)		
§ 401	71 P.S. § 111	311(a)-(d)
§ 448(k)	71 P.S. § 158(k)	312(a)-(d)
§ 448(l)	71 P.S. § 158(l)	312(d)
§ 2313(a)	71 P.S. § 603(a)	301(11)
§ 2313(b)	71 P.S. § 603(b)	301(12)
§ 2328	71 P.S. § 611.8	312(e)(1)-(5)
Act of June 23, 1931 (P.L.1199, No.324)		
§ 1	50 P.S. § 569	Executed
§ 2	50 P.S. § 570	Obsolete
§ 3	50 P.S. § 571	Obsolete
§ 4	50 P.S. § 572	Obsolete
Act of September 29, 1938 (Sp.Sess. P.L.53, No. 21)	50 P.S. 1051	Executed
Act of November 29, 1938 (Sp.Sess. P.L.92, No.37)		
§ 3	50 P.S. 1059	Executed
Act of May 21, 1943 (P.L.469, No.210)		
§ 1	71 P.S. § 1791	Obsolete
§ 1.1	71 P.S. § 1792	Obsolete
§ 2	71 P.S. § 1793	Obsolete
Act of June 1, 1943 (P.L.813, No.342)		
§ 1	71 P.S. § 1519.2	Obsolete
§ 2	71 P.S. § 1519.3	Obsolete
§ 3	71 P.S. § 1519.4	Obsolete
§ 4	71 P.S. § 1519.5	Obsolete
§ 5	71 P.S. § 1519.6	Obsolete
§ 6	Appropriation	Obsolete
Act of April 18, 1949 (P.L.599, No.126)		
§ 1	50 P.S. § 581	701, 702

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of April 18, 1949 (cont.)		
§ 2	50 P.S. § 582	Executed
§ 3.1	50 P.S. § 583.1	703
Act of May 20, 1949 (P.L.1643, No.496)		
§ 1	50 P.S. § 575.1	711
§ 2	50 P.S. § 575.2	712
§ 3	50 P.S. § 575.3	713(a), (b)
§ 4	50 P.S. § 575.4	713(c)
§ 5	50 P.S. § 575.5	714(a)
§ 6	50 P.S. § 575.6	714(b)
§ 7	50 P.S. § 575.7	714(c)
§ 8	Repealer	
Act of May 24, 1951 (P.L.392, No.86)		
§§ 1-5	50 P.S. §§ 589.1-589.5	Saved from repeal
Mental Health and Mental Retardation Act of 1966 Act of October 20, 1966 (Sp.Sess. #3, P.L.96, No.6)		
§ 101	50 P.S. § 4101	Saved from repeal
§ 102	50 P.S. § 4102	102
§ 201(1)-(5)	50 P.S. § 4201(1)-(5)	301(1)-(5)
§ 201(6)	50 P.S. § 4201(6)	see § 313
§ 201(7)	50 P.S. § 4201(7)	301(7)
§ 201(8)	50 P.S. § 4201(8)	301(8)
§ 202(a)	50 P.S. § 4202(a)	301(9)
§ 202(b)	50 P.S. § 4202(b)	301(10)
§ 203	50 P.S. § 4203	304
§ 301(a), (b)	50 P.S. § 4301(a), (b)	501(a)
§ 301(c)	50 P.S. § 4301(c)	312(e)(5), 501(b)
§ 301(d)-(f)	50 P.S. § 4301(d)-(f)	501(c)(1)-(9), (d), (e)
§ 302	50 P.S. § 4302	502
§ 303	50 P.S. § 4303	503
§ 304	50 P.S. § 4304	504
§ 305	50 P.S. § 4305	505

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of October 20, 1966 (cont.)		
§§ 401-412	50 P.S. §§ 4401-4412	Saved from repeal
§ 413	50 P.S. § 4413	Supplied by Ch. 15
§ 414	50 P.S. § 4414	2702
§ 415	50 P.S. § 4415	2507
§ 416	50 P.S. § 4416	Saved from repeal
§ 417	50 P.S. § 4417	2301
§§ 418-420	50 P.S. §§ 4418-4420	Saved from repeal
§ 421	50 P.S. § 4421	2302
§ 422(1)	50 P.S. § 4422(1)	2303(a)
§ 422(2)	50 P.S. § 4422(2)	2303(b)
§ 423	50 P.S. § 4423	2304(a)
§ 424	50 P.S. § 4424	Unconstitutional; see § 2307
§ 425(a)-(c)	50 P.S. § 4425(a)-(c)	2305(a)-(c)
§ 425(d), (e)	50 P.S. § 4425(d), (e)	2305(d)
§ 426	50 P.S. § 4426	Saved from repeal
§ 501	50 P.S. § 4501	121
§ 502	50 P.S. § 4502	122
§ 503	50 P.S. § 4503	123
§ 504	50 P.S. § 4504	124
§ 505(a)	50 P.S. § 4505(a)	125(a)
§ 505(b)	50 P.S. § 4505(b)	125(c)
§ 505(c)	50 P.S. § 4505(c)	125(d)
§ 506	50 P.S. § 4506	126
§ 507	50 P.S. § 4507	127(1)-(4)
§ 508	50 P.S. § 4508	128
§ 509(1)-(6)	50 P.S. § 4509(1)-(6)	129(a)
§ 509(7)	50 P.S. § 4509(7)	129(b)
§ 510	50 P.S. § 4510	Transitional
§ 511	50 P.S. § 4511	Transitional
§ 512(a), (b)	50 P.S. § 4512(a), (b)	Transitional
§ 512(c)-(e)	50 P.S. § 4512(c)-(e)	130(a)-(c)
§ 601	50 P.S. § 4601	305
§ 602(a)-(c)	50 P.S. § 4602(a)-(c)	111(a)-(c)
§ 602(d)	50 P.S. § 4602(d)	112(a)

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of October 20, 1966 (cont.)		
§ 603	50 P.S. § 4603	113(a)
§ 604	50 P.S. § 4604	Saved from repeal
§ 605	50 P.S. § 4605	2306
§ 606	50 P.S. § 4606	Unnecessary
§ 701	50 P.S. § 4701	Repeals
§ 702	50 P.S. § 4702	Interim powers of the department
§ 703	50 P.S. § 4703	Appropriation
§ 704	50 P.S. § 4704	Effective date
Public Welfare Code Act of June 13, 1967 (P.L.31, No.21)		
§ 317(a)	62 P.S. § 317(a)	311(e)
§ 1121	62 P.S. § 1121	2501
§ 1122	62 P.S. § 1122	2502
§ 1123	62 P.S. § 1123	2503
§ 1124	62 P.S. § 1124	2504
§ 1125	62 P.S. § 1125	2505
§ 1126	62 P.S. § 1126	2506
§ 1131	62 P.S. § 1131	2701
§§ 1141-1148	62 P.S. §§ 1141-1148	Obsolete
Parklands Payback Pilot Project Act Act of December 29, 1972 (P.L.1695, No.362)		
§ 1-14	50 P.S. § 6001-6014	Obsolete
§ 15	Effective date	Obsolete
Mental Health Procedures Act Act of July 9, 1976 (P.L.817, No.143)		
§ 101	50 P.S. § 7101	901
§ 102	50 P.S. § 7102	902
§ 103, 1st and 2nd sent.	50 P.S. § 7103, 1st and 2nd sent.	903

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of July 9, 1976 (cont.)		
§ 103, 3rd sent.	50 P.S. § 7103, 3rd sent.	102
§ 104	50 P.S. § 7104	911
§ 105	50 P.S. § 7105	912
§ 106	50 P.S. § 7106	913(a)-(d)
§ 107	50 P.S. § 7107	913(e), (f)
§ 108	50 P.S. § 7108	914
§ 109(a)	50 P.S. § 7109(a)	921(a)
§ 109(b)	50 P.S. § 7109(b)	921(c)
§ 109(c)	50 P.S. § 7109(c)	921(d)
§ 110	50 P.S. § 7110	922
§ 111	50 P.S. § 7111	112(b)(1)-(4), (6), (7), intro. to (c)
§ 112	50 P.S. § 7112	See 301, 305
§ 113	50 P.S. § 7113	915
§ 114(a)	50 P.S. § 7114(a)	113(a)
§ 114(b)	50 P.S. § 7114(b)	113(b)
§ 115(a)	50 P.S. § 7115(a)	923(a), (b)
§ 115(b)	50 P.S. § 7115(b)	Unnecessary
§ 116	50 P.S. § 7116	916
§ 201	50 P.S. § 7201	1101
§ 202	50 P.S. § 7202	1102
§ 203	50 P.S. § 7203	1103
§ 204	50 P.S. § 7204	1104
§ 205	50 P.S. § 7205	1105
§ 206(a)	50 P.S. § 7206(a)	1106
§ 206(b)	50 P.S. § 7206(b)	1107
§ 206(c)	50 P.S. § 7206(c)	917
§ 207	50 P.S. § 7207	1108
§ 301(a)	50 P.S. § 7301(a)	1301(a)
§ 301(b)(1)	50 P.S. § 7301(b)(1)	1301(b), (d)
§ 301(b)(2)(i)	50 P.S. § 7301(b)(2)(i)	1301(c)(1)
§ 301(b)(2)(ii)	50 P.S. § 7301(b)(2)(ii)	1301(c)(2), (d)
§ 301(b)(2)(iii)	50 P.S. § 7301(b)(2)(iii)	1301(c)(3), (d)
§ 302(a) 1st sent.	50 P.S. § 7302(a) 1st sent.	1302(a)
§ 302(a)(1)	50 P.S. § 7302(a)(1)	1302(b)
§ 302(a)(2)	50 P.S. § 7302(a)(2)	1302(c)
§ 302(b)	50 P.S. § 7302(b)	1302(d)
§ 302(c) 1st 3 sent.	50 P.S. § 7302(c) 1st 3 sent.	1302(e)

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of July 9, 1976 (cont.)		
§ 302(c) last sent.	50 P.S. § 7302(c) last sent.	1302(f)
§ 302(d)	50 P.S. § 7302(d)	1302(g)
§ 303(a)-(f)	50 P.S. § 7303(a)-(f)	1303(a)-(f)
§ 303(g)	50 P.S. § 7303(g)	Unnecessary see § 921
§ 303(h)	50 P.S. § 7303(h)	1303(g)
§ 304(a)(1)	50 P.S. § 7304(a)(1)	1304(b)
§ 304(a)(2)	50 P.S. § 7304(a)(2)	1304(a)(3)
§ 304(b)(1)	50 P.S. § 7304(b)(1)	1304(a)(1)
§ 304(b)(2) 1st sent.	50 P.S. § 7304(b)(2) 1st sent.	1304(a)(2)-(3)
§ 304(b)(2) 2nd & 3rd sent.	50 P.S. § 7304(b)(2) 2nd & 3rd sent.	1304(a)(4)
§ 304(b)(3)	50 P.S. § 7304(b)(3)	1304(a)(5)
§ 304(b)(4)	50 P.S. § 7304(b)(4)	1304(a)(6)
§ 304(b)(5)	50 P.S. § 7304(b)(5)	1304(a)(7)
§ 304(c)	50 P.S. § 7304(c)	1304(b)
§ 304(d)	50 P.S. § 7304(d)	1304(c)
§ 304(e)(1)	50 P.S. § 7304(e)(1)	1304(a)(5), (b)(4)
§ 304(e)(2), (3)	50 P.S. § 7304(e)(2), (3)	1304(d)(1)
§ 304(e)(4)	50 P.S. § 7304(e)(4)	1304(d)(2)
§ 304(e)(5)	50 P.S. § 7304(e)(5)	1304(d)(3)
§ 304(e)(6)	50 P.S. § 7304(e)(6)	921(a), 1304(d)(4)
§ 304(e)(7)	50 P.S. § 7304(e)(7)	1304(d)(5)
§ 304(f)	50 P.S. § 7304(f)	1304(e)
§ 304(g)(1)	50 P.S. § 7304(g)(1)	1304(f)
§ 304(g)(2)-(4)	50 P.S. § 7304(g)(2)-(4)	1304(g)(1)-(3)
§ 305(a)	50 P.S. § 7305(a)	1305(a)-(d)
§ 305(b)	50 P.S. § 7305(b)	1304(h), 1305(e)
§ 306	50 P.S. § 7306	1306(a)-(c)
§ 401(a)	50 P.S. § 7401(a)	1501(a)
§ 401(a) last sent.	50 P.S. § 7401(a) last sent.	1501(c)
§ 401(b) 1st 3 sent.	50 P.S. § 7401(b) 1st 3 sent.	1501(b)
§ 401(b) 4th and 5th sent.	50 P.S. § 7401(b) 4th and 5th sent.	1501(c)
§ 401(b) 6th sent.	50 P.S. § 7401(b) 6th sent.	1501(d)
§ 401(b) 7th sent.	50 P.S. § 7401(b) 7th sent.	1501(e)

Statute	Purdon's title	Pa.C.S. Title 50
Section	Section	Section
Act of July 9, 1976 (cont.)		
§ 402(a)-(d)	50 P.S. § 7402(a)-(d)	1502(a)-(d)
§ 402(e)(1)-(3)	50 P.S. § 7402(e)(1)-(3)	1502(e)
§ 402(e)(4)(i), (ii)	50 P.S. § 7402(e)(4)(i), (ii)	1502(f)
§ 402(e)(4) (iii), (iv)	50 P.S. § 7403(e)(4) (iii), (iv)	1502(g)
§ 402(f), (g)	50 P.S. § 7402(f), (g)	1502(h), (i)
§ 403	50 P.S. § 7403	1503
§ 404	50 P.S. § 7404	1504
§ 405	50 P.S. § 7405	1505
§ 406	50 P.S. § 7406	1506
§ 407	50 P.S. § 7407	1507
§ 408	50 P.S. § 7408	125(b)
§ 501	50 P.S. § 7501	Effective date and applica- bility
§ 502	50 P.S. § 7502	Repeals
§ 503	50 P.S. § 7503	Severability
Act of July 9, 1987 (P.L.207, No.32)		
§ 1	___ P.S. ___	302(a), (b)
§ 2	Repealer	
§ 3	Effective date	

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