

**JOINT STATE
GOVERNMENT COMMISSION**
General Assembly of the Commonwealth of Pennsylvania

**MENTAL HEALTH SERVICES
AND THE CRIMINAL JUSTICE SYSTEM
IN PENNSYLVANIA**

STAFF REPORT

MAY 2014



JOINT STATE GOVERNMENT COMMISSION
Serving the Pennsylvania General Assembly Since 1937

The Joint State Government Commission was created by the act of July 1, 1937 (P.L.2460, No.459), as amended, and serves as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.

Joint State Government Commission

**Room 108 Finance Building
613 North Street
Harrisburg, PA 17120-0018**

Telephone: 717-787-4397

Fax: 717-787-7020

E-mail: jntst02@legis.state.pa.us

Website: <http://jsg.legis.state.pa.us>

Project Manager: Yvonne Llewellyn Hursh, Assistant Counsel

Project Staff: Mark A. Bogush, Public Policy Analyst
Michael P. Dirckx, Staff Attorney
Yelena P. Khanzhina, Public Policy Analyst
Wendy L. Baker, Executive Assistant



General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION

ROOM 108 – FINANCE BUILDING
HARRISBURG, PA 17120

PHONE: 717-787-4397/**FAX:** 717-787-7020
<http://jsg.legis.state.pa.us/>

May 6, 2014

FLORINDO J. FABRIZIO
Chairman
JOHN C. RAFFERTY, JR.
Vice Chairman

To the Members of the General Assembly of Pennsylvania:

EXECUTIVE COMMITTEE

SENATE MEMBERS:

JOSEPH B. SCARNATI, III
President Pro Tempore
DOMINIC F. PILEGGI
Majority Leader
JAY COSTA
Minority Leader
PATRICK M. BROWNE
Majority Whip
ANTHONY H. WILLIAMS
Minority Whip
JOHN R. GORDNER
Chair, Majority Caucus
RICHARD A. KASUNIC
Chair, Minority Caucus

HOUSE MEMBERS:

SAMUEL H. SMITH
Speaker
MICHAEL C. TURZAI
Majority Leader
FRANK J. DERMODY
Minority Leader
STANLEY E. SAYLOR
Majority Whip
MICHAEL K. HANNA
Minority Whip
SANDRA J. MAJOR
Chair, Majority Caucus
DAN B. FRANKEL
Chair, Minority Caucus

ADMINISTRATIVE STAFF:

GLENN J. PASEWICZ
Executive Director
STEPHEN F. REHRER
Counsel

House Resolution 226 of 2013 directed the Joint State Government Commission to conduct a study of all aspects of Pennsylvania's mental health system and report back with specific recommendations for amendment and improvement, particularly as to how criminal defendants with mental illness are addressed by established procedures, policies, and programs.

This report reviews the structure of the mental health system in Pennsylvania, the various programs, policies, and procedures currently in place to assist persons with mental illness and makes recommendations to improve the delivery of mental health services by the Departments of Corrections, Drug and Alcohol Programs, and Public Welfare and the Commonwealth's 48 county mental health and intellectual disability programs. Special attention has been paid to the provision of mental health services to persons involved in the criminal justice system. Additionally, this report recommends the codification of the Mental Health Procedures Act.

During the course of this study, the Commission requested input from various stakeholders in the mental health and criminal justice systems. Their insight and knowledge were extremely helpful in formulating this report. The Commission is grateful for the advice and information received.

Sincerely,

Glenn Pasewicz
Executive Director

JOINT STATE GOVERNMENT COMMISSION

The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.¹

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs.

By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

¹ Act of July 1, 1937 (P.L.2460, No.459), amended by the act of June 26, 1939 (P.L.1084, No.380), the act of March 8, 1943 (P.L.13, No.4), the act of May 15, 1955 (P.L.1605, No.535), the act of December 8, 1959 (P.L.1740, No.646), and the act of November 20, 1969 (P.L.301, No.128).

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.² Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth of Pennsylvania receives the financial benefit of such volunteerism, along with the expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report.

A report containing proposed legislation may also contain official comments, which may be used in determining the intent of the General Assembly.³

² Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. However, it does, at a minimum, reflect the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

³ 1 Pa.C.S. § 1939 (“The comments or report of the commission . . . which drafted a statute may be consulted in the construction or application of the original provisions of the statute if such comments or report were published or otherwise generally available prior to the consideration of the statute by the General Assembly”).

Since its inception, the Commission has published more than 350 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

ACKNOWLEDGEMENTS

During the course of this study, the Commission requested input from various stakeholders in the mental health and criminal justice systems. Their insight and knowledge were extremely helpful in formulating this report. However, their recognition in this section should not in any way be read to be an endorsement of any specific recommendations or conclusions presented herein. The Commission gratefully acknowledges the advice and information received from the following organizations and individuals:

- Taylor P. Andrews, Esq.
- Hollie Ayers
- Judy Banks, Acting Chief Executive Director, Disabilities Rights Network of Pennsylvania
- Mark H. Bergstrom, Executive Director, Pennsylvania Commission on Sentencing
- Leo L. Dunn, Director, Policy and Legislative Affairs, Pennsylvania Board of Probation and Parole
- Sharon Engdahl, President, The Mental Wellness Awareness Association
- Patricia A. Griffin, Ph.D., Senior Consultant, Pennsylvania Mental Health and Justice Center of Excellence
- Kirk Heilbrun, Ph.D., Department of Psychology, Drexel University, Co-Director of the Pennsylvania Mental Health and Justice Center of Excellence
- Carol Horowitz, Managing Attorney, Disability Rights Network of PA
- Lynn Keltz, Executive Director, PA Mental Health Consumers' Association
- Samuel J. Knapp, Ed.D., Director of Professional Affairs, Pennsylvania Psychological Association

- Dennis Marion, Deputy Secretary for Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare
- Robert Marsh, Psy.D., Chief, Office of Psychological Services, Pennsylvania Department of Corrections
- Robert K. Merwine, Director, Pennsylvania Commission on Crime and Delinquency
- Christine Michaels, Executive Director, NAMI Southwestern Pennsylvania
- Ed Michalik, Psy.D., Administrator, Berks County Mental Health/Developmental Disabilities Program
- Edward P. Mulvey, Ph.D., Western Psychiatric Institute and Clinic, Law & Psychiatry Program, University of Pittsburgh School of Medicine, Co-Director, Pennsylvania Mental Health and Justice Center of Excellence
- Lynn Patrone, Executive Assistant to the Deputy Secretary for Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare
- Brinda Carroll Penyak, Deputy Director, County Commissioners Association of Pennsylvania
- Candice T. Player, Stephanie and Michael Naidoff Fellow in Health Policy, Law and Medicine, University of Pennsylvania Law School
- Jessica Reichenbach, Mental Health Program Representative, Office of Mental Health & Substance Abuse Services, Pennsylvania Department of Public Welfare
- Linda Rosenberg, Executive Director, Pennsylvania Commission on Crime and Delinquency
- Kristen Rotz, Executive Director, Pennsylvania Association of County Administrators of Mental Health and Developmental Services
- Jack Rozel, M.D., M.S.L., Medical Director, Western Psychiatric Institute and Clinic of UPMC

- Jean Rush, Bureau of Program and Policy Development, Office of Mental Health & Substance Abuse Services, Pennsylvania Department of Public Welfare
- Deborah Ann Shoemaker, Executive Director, Pennsylvania Psychiatric Society
- Sue Walther, Executive Director, Mental Health Association in Pennsylvania
- Honorable John A. Zottola, Judge, Fifth Judicial District of Pennsylvania, County of Allegheny and Chair, Mental Health and Justice Advisory Committee, Pennsylvania Commission on Crime and Delinquency.

TABLE OF CONTENTS

INTRODUCTION	1
RECOMMENDATIONS	7
LAWS GOVERNING THE MENTAL HEALTH SYSTEM AND TREATMENT OF PERSONS WITH MENTAL ILLNESS	11
<i>Mental Health and Intellectual Disability Act of 1966</i>	11
<i>Mental Health Procedures Act</i>	12
<i>Voluntary Treatment</i>	12
<i>Civil Involuntary Examination and Treatment</i>	12
<i>Forensic Examination and Treatment</i>	14
<i>Other Pennsylvania Laws</i>	15
<i>Continuity of Care</i>	15
<i>Administrative Statutes</i>	16
<i>Advance Directive for Mental Health/Mental Health Power of Attorney</i>	16
<i>Proposed Legislation, 2013-2014</i>	16
THE MENTAL HEALTH DELIVERY SYSTEM	19
<i>The Pennsylvania Department of Public Welfare</i>	19
<i>State Hospital System</i>	20
<i>Clarks Summit State Hospital</i>	21
<i>Danville State Hospital</i>	21
<i>Norristown State Hospital</i>	21
<i>Torrance State Hospital</i>	21
<i>Warren State Hospital</i>	22
<i>Wernersville State Hospital</i>	22
<i>South Mountain Restoration Center</i>	22
<i>The Olmstead Plan</i>	22
<i>County Mental Health/Intellectual Disability Programs</i>	23
<i>Evidence-Based Practices</i>	26
<i>Peer Support Specialists</i>	33
<i>Other Innovative Programs</i>	33
MENTAL HEALTH SERVICES IN THE CRIMINAL JUSTICE SYSTEM	35
<i>The Pennsylvania Department of Corrections</i>	35
<i>Forensic Treatment Center at Waymart State Correctional Institution</i>	37
<i>Bureau of Community Corrections</i>	37
<i>Pennsylvania Department of Public Welfare</i>	37
<i>Regional Forensic Unit at Norristown State Hospital</i>	38
<i>Regional Forensic Psychiatric Center at Torrance State Hospital</i>	38
<i>County Correctional Institutions</i>	39
<i>Pennsylvania Commission on Crime and Delinquency</i>	39

<i>Mental Health and Justice Advisory Committee</i>	40
<i>Pennsylvania Mental Health and Justice Center of Excellence</i>	40
<i>Justice Reinvestment Working Group</i>	41
<i>Criminal Justice Advisory Boards (CJABs)</i>	41
<i>Pennsylvania Board of Probation and Parole</i>	41
FUNDING PENNSYLVANIA’S MENTAL HEALTH SYSTEM	43
<i>State Mental Health Services Expenditures</i>	43
<i>State Funding for Community Mental Health/Intellectual Disability Programs</i>	44
<i>Human Services Block Grant Pilot Program</i>	46
<i>Community Mental Health Services Block Grants</i>	47
<i>Community Hospital Integration Projects Program (CHIPP)</i>	49
<i>Justice Reinvestment Initiative</i>	50
<i>Melville 811 Resources</i>	50
<i>Insurance Parity</i>	50
<i>Medicaid Expansion</i>	52
<i>Medicaid for Inmates</i>	52
<i>Estate Recovery</i>	53
AREAS OF CONCERN: THE MENTAL HEALTH SYSTEM	55
<i>Current Involuntary Commitment Standards</i>	55
<i>Clear and Present Danger of Harm to Others</i>	55
<i>Clear and Present Danger of Harm to Self</i>	56
<i>Problematic Standards</i>	56
<i>Assisted Outpatient Commitment</i>	58
<i>Duty to Protect</i>	61
<i>Availability of Psychiatric Inpatient Beds</i>	63
<i>Shortage of Mental Health Professionals</i>	68
AREAS OF CONCERN: THE CRIMINAL JUSTICE SYSTEM	71
<i>U.S. Department of Justice Investigation</i>	71
<i>Length of Stay</i>	75
<i>Waiting Lists for Services</i>	76
<i>Sequential Intercept Model</i>	76
<i>Intercept 1: Law Enforcement and Emergency Services</i>	78
<i>Intercept 2: Initial Detention and Initial Hearings</i>	80
<i>Intercept 3: Jail, Courts, Forensic Evaluations, and Forensic Commitments</i>	81
<i>Intercept 4: Reentry from Jails, State Prisons, and Forensic Hospitalization</i>	84
<i>Intercept 5: Community Corrections and Community Support</i>	88
<i>Other States’ Diversion Programs</i>	90
PROPOSED LEGISLATION	91
MENTAL HEALTH PROCEDURES ACT (1976)	155
SOURCE AND DISPOSITION TABLES	177
<i>Source Table for Proposed Title 50, Part III of the Pennsylvania Consolidated Statutes</i>	177
<i>Disposition Table for Mental Health Procedures Act</i>	181
HOUSE RESOLUTION 226	185

INTRODUCTION

“You're frightened, and you're frightening, and you're ‘not at all like yourself but will be soon,’ but you know you won't.”⁴

Serious mental illness, usually defined as schizophrenia, major depression, bipolar disorder, obsessive compulsive disorder, panic disorder, posttraumatic stress disorder and borderline personality disorder, affects between four and five percent of the American population. While treatment modalities have improved greatly in the past 100 years, many individuals with mental illness still struggle to find needed services, frequently resulting in their incarceration in county jails and state prisons.

In recognition of these continuing struggles within the mental health and criminal justice communities, 2013 House Resolution No. 226 directs the staff of the Joint State Government Commission to conduct a study “of all aspects of Pennsylvania's mental health system and report back with specific recommendations for amendment and improvement, particularly as to how criminal defendants with mental illness are addressed by established procedures, policies and programs.”⁵

Treatment of persons with mental illness has evolved tremendously over the past 150 years. Many treatment options were initially developed based on the perceived cause of mental illness. Demonic possession and spiritual and moral decay were early presumed culprits. Social and emotional interactions in childhood have also been cited as causes of mental illness, most famously by Sigmund Freud. “Refrigerator moms” and bad mothering were believed to be the cause of schizophrenia and autism in the mid-20th century. Chemical imbalances, organic brain disease, and genetics have most recently been identified as medical causes of mental illness. Mental institutions evolved in the 19th century as a protected shelter for persons with mental illness, and by the early 20th century, attempts at treatment, such as insulin shock, electroshock therapy, and surgery were made.

⁴ Kay Redfield Jamison, Ph.D., *An Unquiet Mind: A Memoir of Moods and Madness* (New York Vintage Books, 1996). Dr. Jamison is a clinical psychologist who has bipolar disorder. She currently serves as Co-Director of the Mood Disorders Center at Johns Hopkins University.

⁵ *Infra*, at page 189.

By the 1940s and 50s, Pennsylvania had almost 20 state mental hospitals.⁶ Most of these institutions were built in the period 1870-1920, with the last new hospital built at Haverford (Delaware County) in 1964. Originally intended to provide quiet living in rural settings, many institutions had farms and workshops that provided an early form of vocational therapy. However, problems developed with overcrowding, frequently transforming asylums as places of refuge into warehouses, where mentally disturbed people were locked away and forgotten. The forced labor assignments at farms and in workshops without financial compensation became viewed as a form of peonage. Forced medical treatment and excessive use of restraints were challenged as violations of patient civil rights. The development of psychotropic drugs in the 1950s helped promote and encourage the idea that with appropriate medication, many persons with mental illness could function in the community. Personal liberty could be restored to all but those with particularly intractable mental disorders. Since the early 1980s, the Commonwealth has closed or transferred to other usage all but six of its state mental hospitals.

Deinstitutionalization of persons with mental illness did not and does not cure mental illness. Persons continue to need a variety of psychiatric and psychological supportive services and frequently need assistance in finding housing and employment. Psychotropic drugs only work if they are taken as prescribed. And while they can allow an individual to function “normally,” they are not a panacea and are usually accompanied by side effects that are far from benign. As with non-psychotropic medications, some people stop taking medication as soon as they start to feel better. In physical medicine, such behavior has contributed to the rise of antibiotic-resistant bacteria. In mental health, this can lead to the recurrence of symptoms, psychological deterioration and ultimately re-institutionalization. Additionally, families of persons with mental illness need advice and support.

Younger persons with serious mental illness, born since the deinstitutionalization movement began and who were not subject to institutionalization in state mental hospitals, rely heavily on community mental health resources. When there are insufficient resources and a person with serious mental illness begins to experience active symptoms, their lack of treatment frequently results in interaction with the criminal justice system. Many people who might have received treatment in a state mental institution 70 years ago find themselves in a county jail or state prison, where the state and local corrections systems are expected to provide treatment for them – a role for which they were not designed. It is particularly ironic that three former state mental hospitals (Lawrence Frick, Retreat and

⁶ Those hospitals included Allentown (Lehigh County), Clarks Summit (Lackawanna County), Danville (Montour County), Dixmont (Allegheny County), Embreeville (Chester County), Farview (Wayne County), Harrisburg (Dauphin County), Hollidaysburg (Blair County), Mayview (Allegheny County), Norristown (Montgomery County), Philadelphia (Philadelphia County), Retreat (Luzerne County), Somerset (Somerset County), Torrance (Westmoreland County), Warren (Warren County), Wernersville (Berks County), and Woodville (Allegheny County). Joint State Government Commission, General Assembly of the Commonwealth of Pennsylvania, “Biennial Report of the Joint State Government Commission, 1959-1961,” http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=250.

Somerset) were closed and then reopened as SCI⁷ Cresson, SCI Retreat and SCI Laurel Highlands, respectively.⁸

A recent study by E. Fuller Torrey, M.D., and several of his colleagues at the Treatment Advocacy Center found that in 2004-2005, there were three times as many persons with serious mental illness in jails and prisons than in hospitals in the United States. The study found Pennsylvania to have two persons with mental illness in prison for every one person in a psychiatric hospital or unit.⁹ In many ways, jails have become the new state mental institutions. This is not a phenomena restricted to Pennsylvania: “Today, our largest mental hospitals are our jails. The jail at New York’s Rikers’ Island functions as the nation’s largest psychiatric facility. Los Angeles jails – not its hospitals – are California’s largest providers of mental health care.”¹⁰ The City of New York Department of Correction recently revealed that the proportion of inmates at Rikers Island with a diagnosed mental illness has grown from 20 percent to 40 percent over the past eight years.¹¹

The principle directive of the Pennsylvania Department of Corrections (DOC) is corrections. Treatment of mental illness among inmates is one of several ancillary services DOC must provide for the welfare of its inmates. Serious problems developed at SCI Cresson regarding the treatment of prisoners with mental illness, leading to a statewide U.S. Department of Justice investigation into allegations of violations of the Americans with Disability Act¹² and the civil rights of prisoners, in particular their 8th amendment protection from cruel and unusual punishment. SCI Cresson is shuttered once again, and DOC has begun a massive overhaul of its internal mental health system and will require an additional \$10 million in mental health staffing expenditures alone.¹³

As the Pennsylvania Department of Public Welfare (DPW) slowly decreases the populations of its state mental hospitals, with the goal of institutionalizing only those persons with serious mental illness who cannot safely function in the community, DOC is requesting more and more budget increases to fund a mental health system within its facilities, a role it was never intended to fulfill. Community mental health services, the system best equipped and designed to assist the greatest number of persons with mental illness in the community, continues to experience financial difficulties.

⁷ SCI means State Correctional Institution.

⁸ The state mental hospital for the criminally insane, formerly known as Farview, was turned over to the Department of Corrections in 1995 and became the forensic unit SCI Waymart.

⁹ E. Fuller Torrey, M.D., Sheriff Aaron D. Kennard (retired), M.P.A., Sheriff Don Eslinger, Richard Lamb, M.D. and James Pavle, “More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States,” Treatment Advocacy Center and National Sheriffs’ Association, May 2010.

¹⁰ Amanda Pustilnik, quoted by Allen Francis, M.D., “Prison or Treatment For the Mentally Ill,” *Psychology Today*, March 10, 2013, <http://www.psychologytoday.com/blog/saving-normal/201303/prison-or-treatment-the-mentally-ill>.

¹¹ Michael Schwartz, “Rikers Island Struggles With a Surge in Violence and Mental Illness,” *The New York Times*, March 18, 2014, http://www.nytimes.com/2014/03/19/nyregion/rise-in-mental-illness-and-violence-at-vast-jail-on-rikers-island.html?_r=0.

¹² Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101-12213 (2000).

¹³ Appropriations Committee hearing, Pennsylvania House of Representatives, “Budget Request FY 2014-2015, Secretary John E. Wetzel, Pennsylvania Department of Corrections,” February 12, 2014.

According to the federal Department of Health and Human Services, 18.6 percent of the United States population in 2012 suffered from some type of mental illness. Serious mental illness affected 4.1 percent of the general populace.¹⁴ Using information from the 2010 United States Census, these percentages equate to 1,484,954 adults aged 18-65 living in Pennsylvania who suffer from some form of mental illness, with 327,329 of them experiencing serious mental illness. According to the DPW, 720,079 individuals received community mental health services in fiscal year 2012-2013.¹⁵ This group includes not only adults with serious mental illness, but also those with any type of mental health problem; it also includes children, youth and older Pennsylvanians and is less than half of the estimated number of adults in Pennsylvania who suffer from any form of mental illness.

The maximum capacity of all the state correctional institutions is approximately 50,000. According to the DOC, as of December 31, 2013, 19.6 percent of their inmates (approximately 9,800) suffer from some form of mental illness. Current DOC data indicate that serious mental illness affects 5.6 percent of their inmates, or approximately 2,800 individuals. However, it is believed that that number is underestimated due to the type of diagnostic categories used; the number may actually be closer to 10 percent, or 5,000 inmates with serious mental illness in the state correctional institutions.¹⁶ For calendar year 2012, county prisons statewide reported an average daily in-house population of 37,185, plus another 1,919 inmates housed elsewhere, for a total average daily census of 39,104. The prisons further reported that as of January 31, 2013, they had a total of 11,305 inmates on their mental health caseloads. Those figures indicate that on average, 28.9 percent of inmates in county jails have some form of mental health need.¹⁷

¹⁴ Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, "Substance Use and Mental Disorders: Early Detection, Prevention and Treatment: A Healthy People 2020 Progress Review," February 26, 2014, at page 11. The National Institute of Mental Health, reports that 26.2% of U.S. adults have any type of mental disorder and 5.8% are classified as severe. However, those estimates are based on 2005 studies. National Institute of Mental Health, National Institutes of Health, "Statistics: Any Disorder Among Adults," http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml.

¹⁵ Commonwealth of Pennsylvania, Governor's Executive Budget, 2014-2015 at page E37.37.

¹⁶ Telephone conference with Robert Marsh, Psy.D., Chief, Office of Psychological Services, Pennsylvania Department of Corrections, February 10, 2014. *See also*, Bureau of Planning, Research and Statistics, Department of Corrections, Commonwealth of Pennsylvania, "2014-2015 Budget Overview," February, 2014.

¹⁷ These figures are estimates based on information provided by the county prisons. There are 62 county prisons in Pennsylvania. Thirteen counties reported that they did not have any inmates on their mental health caseloads. They are Allegheny, Clarion, Greene, Huntingdon, Lackawanna, Lehigh, Montour, Northumberland, Potter, Tioga, Warren, Washington, and Wyoming Counties. If the average daily census of these jails are removed from the calculation, the percentage of persons with mental health issues who are incarcerated increases to 34.2%. Commonwealth of Pennsylvania, Department of Corrections, County Prisons, Statistics and General Information, "2013 County Statistics," http://www.cor.state.pa.us/portal/server.pt/community/county_prisons/28063/inspection_schedule_%2C_statistics_and_general_info_/1170613.

From a purely fiscal perspective, community mental health services are a bargain. The average cost per person in a state mental hospital in Pennsylvania is \$144,072.¹⁸ The average cost per inmate in the state corrections institutions is \$36,300.¹⁹ Average costs per day per inmate in county jails in 2012 ranged from a low of \$15 per day (\$5,475 per year) in Northumberland County to a high of \$136.99 per day (\$50,001 per year) in Elk County, with an average rate of \$68.19 per day (\$24,889 per year).²⁰ The average expenditure per person receiving community mental health services is \$2,322.²¹

The cost of jailing persons with mental illness has been examined in several other states and found to be more expensive than providing mental health services in the community. In Santa Barbara County, California, a 2013 study found that it costs \$52,500 to incarcerate a person with mental illness in the county jail. It also determined that the county spent \$19,000 more to incarcerate persons with mental illness than it would to treat people with mental health problems in stabilized housing.²² In Connecticut, persons with mental illness involved in the criminal justice system in 2006 and 2007 incurred \$48,980 in costs, nearly double the \$24,728 in costs incurred by mentally ill persons not involved in the system.²³ A study in Pinellas County, Florida from fiscal year 2003-2004 found a median expenditure per person with serious mental illness of \$15,134. The highest expenditures were for persons at least 40 years old with a psychotic disorder, a psychiatric examination, and a record of multiple arrests and mental health contacts.²⁴

Nationwide, state mental health budgets have been declining. In the period 2009-2012, 28 states, including Pennsylvania, saw decreases in spending. The loss of federal stimulus money for Medicaid in 2011 has helped contribute to this declining financial support.²⁵ Pennsylvania has experienced “a decade of underfunding, budget cuts and freezes,” including a ten percent cut in the fiscal year 2012-2013 Commonwealth budget.²⁶ Despite Pennsylvania’s ranking as second in per capita expenditures for mental health services nationwide (\$280.78 per person in 2010),²⁷ counties, after several years of streamlining programs and attempting to improve efficiencies, have begun to reduce

¹⁸ *Supra*, note 15.

¹⁹ *Ibid.* at page E13.13.

²⁰ *Supra*, note 17.

²¹ *Supra*, note 15.

²² Kelsey Brugger, “Report examines high cost of jailing mentally ill,” *Santa Barbara Independent*, <http://www.independent.com/news/2014/jan/09/report-examines-high-cost-jailing-mentally-ill/>, January 9, 2014.

²³ Jeffrey W. Swanson, Ph.D.; Linda K. Frisman, Ph.D.; Allison Gilbert Robertson, Ph.D., M.P.H.; Hsiu-Ju Lin, Ph.D.; Robert L. Trestman, Ph.D., M.D.; Deborah A. Shelton, Ph.D., R.N.; Kathryn Parr, Ph.D.; Eleni Rodis, M.S.; Alec Buchanan, Ph.D., M.D.; and Marvin S. Swartz, M.D., “Costs of Criminal Justice Involvement Among Persons With Serious Mental Illness in Connecticut,” *Psychiatric Services*, July 1, 2013.

²⁴ John Petriola, J.D., LL.M.; Ross Andel, Ph.D.; Robert Constantine, Ph.D., M.P.H.; and John Robst, Ph.D., “Public Expenditures Related to the Criminal Justice System and to Services for Arrestees With a Serious Mental Illness,” *Psychiatric Services*, May 1, 2010.

²⁵ National Alliance on Mental Illness, “State Mental Health Cuts: The Continuing Crisis,” Appendix III: State Mental Health Budgets FY2009-FY2012, November 2011.

²⁶ Pennsylvania Association of County Administrators of Mental Health and Developmental Services, “2012-2013 Budget Cut Impacts for Mental Health and Developmental Services,” December 2012. www.mhdspa.org.

²⁷ *Supra*, note 25.

program and service capacity at the local level and to eliminate programs and services due to insufficient funding.²⁸

Community mental health services are considerably less expensive than supporting persons with mental illness in state hospitals or correctional institutions. Additionally, the counties should be able to provide programs and services that prevent most persons with mental illness from reaching the condition where some form of institutionalization is necessary. The cost savings to the state mental institutions and the corrections system can then be used to help maintain and finance those county programs.

This report describes the existing mental health system in Pennsylvania, reviews the Mental Health Procedures Act,²⁹ and makes recommendations to amend the statute to improve its interpretation and application. The report further examines the treatment of mentally ill persons within the criminal justice system, reviews existing programs and policies designed to address the needs of such persons, and makes recommendations to improve methods of preventing incarceration of persons with mental illness.

This review and the accompanying proposed recommendations support the following conclusion: the most cost-efficient and humane way to avoid the institutionalization of persons with mental illness, whether in a state or private mental institution, county jail, or state prison, is to support a robust system of community mental health services, with an emphasis on intercepting and diverting persons with serious mental illness before they become involved in the criminal justice system. While we acknowledge that there are some people whose illness is so intractable that involuntary commitment and treatment are necessary, and that there are others who are criminals who happen to have mental health issues, the vast majority of people suffering from mental illness function better and are capable of contributing to society if they are supported in the community.

²⁸ *Supra*, note 26.

²⁹ Act of July 9, 1976, P.L.817, No. 143, 50 P.S.A. §7101 et seq.

RECOMMENDATIONS

Recommendations resulting from this study include suggestions that staff believe will result in improvements to the mental health system in Pennsylvania, but that require further study or whose specific details or implementation timeline are matters better left to the discretion of the General Assembly and the individual executive departments responsible for those areas of service. The recommendations also include proposed revisions to The Mental Health Procedures Act that can be statutorily implemented with the enactment of the proposed codification and related amendments found in this report.

Recommendation #1

All levels of government in Pennsylvania should make a concerted effort to further develop and support the community mental health services system. A vigorous system can achieve many overlapping goals: keeping persons with mental illness out of inpatient settings, especially state hospitals; reducing the number of persons with mental illness who are incarcerated in jails and prisons; reducing the pressures on state correctional institutions to provide services they are not designed to provide and cannot afford; and most importantly, permitting most people with serious mental illness to function more completely in society, through maintaining employment, paying taxes, and participating in their communities. This goal requires cooperation and communication at the local level between judges, prosecutors, public defenders, local law enforcement, county commissioners, and service providers. (p. 76)

Recommendation #2

The Pennsylvania Department of Public Welfare (DPW) and its Office of Mental Health and Substance Abuse Services (OMHSAS) should continue to develop guidance for counties on prioritizing, developing and implementing evidence-based practices that have shown the greatest success in supporting persons with mental illness in the community. (p. 26, 76)

Recommendation #3

Consistent with Recommendations #1 and #2, all the key stakeholders in the community mental health and criminal justice systems should avail themselves of education and training with regard to methods of intercepting persons with mental illness in the criminal justice system and to the value and appropriateness of adopting evidence-based practices as part of their continuum of services available in each county. The Pennsylvania Mental Health and Justice Center of Excellence, the Pennsylvania

Commission on Crime and Delinquency (PCCD), and DPW's training institutes at Drexel University, Penn State University and the Western Psychiatric Institute and Clinic are resources available to all stakeholders statewide. Professional organizations and trade associations can also offer training opportunities to their members. Police currently undergo training with regard to encountering persons with mental illness, and that training is encouraged to continue. (p. 34)

Recommendation #4

Overall spending on community mental health services should be increased, to reverse the effects of the past decade of declining budget allotments. Additionally, county human service budgets should be reviewed to ensure that financial support is directed to those evidence-based programs that have the greatest potential to assist persons with mental illness to remain in the community. (p. 43)

Recommendation #5

Insurance parity rules should be extended in Pennsylvania to include insurers in the small group market, which can help provide insurance coverage for mental illness for employees of smaller businesses that offer health insurance benefits. (p. 50)

Recommendation #6

DPW and the Department of Drug and Alcohol Programs (DDAP) should continue to explore ways in which integrated treatment can be jointly delivered to persons with mental illness and a co-occurring drug or alcohol disorder. (p. 31)

Recommendation #7

The Mental Health Procedures Act should be codified as part of Title 50 (Mental Health) of the Pennsylvania Consolidated Statutes. The codification should clarify language originally composed in 1976. The proposed codification should also amend the definition of dangerousness in several ways. The definition of danger to others should be amended to include causing substantial property damage as behavior that may result in involuntary treatment. Danger to self through self-neglect should be modified in two ways: (1) to include mental as well as physical deterioration as a possible result of self-neglect, and (2) to broaden the "look-back" period to identify a pattern of behavior that will likely result in the person becoming a danger to self within the next 30 days. Both of these provisions should be limited to persons with a serious mental illness, which should be defined by DPW in its regulations.³⁰ It is hoped that these relatively minor adjustments

³⁰ Currently, the only legal definition of serious mental illness in Pennsylvania is found in DPW regulations to determine eligibility for psychiatric rehabilitation services, 55 Pa.Code § 5230.31. The definition includes

will aid families in obtaining assistance at an earlier stage for mentally ill loved ones who are experiencing a downward spiral, but will not “open the floodgates” to such a degree as to overwhelm an already stressed mental health system. (p. 56)

A proposed codification of Mental Health Procedures Act is included in this report, which attempts to modernize the style and language of the law, as well as clarify specific provisions and reconcile perceived internal inconsistencies in the statute. Where recommendations for change are included in the proposed codification, they are clearly identified and include comments. (p. 91)

Recommendation #8

Pennsylvania should codify its existing duty to warn, currently found in case law, into a statutory requirement delineating the need and limits of a duty to protect. (p. 61)

Recommendation #9

The Pennsylvania Departments of Public Welfare and Health should continue to work with the Pennsylvania Medical Society and other stakeholders in developing a voluntary, real-time database of available psychiatric beds for use by hospital emergency rooms seeking to arrange inpatient hospitalization for persons with mental illness. (p.63)

Recommendation #10

Licensed clinical psychologists should be authorized to involuntarily commit an individual for emergency evaluation and treatment under section 302 of the Mental Health Procedures Act. (p. 68)

Recommendation #11

The General Assembly should consider some form of student loan forgiveness program to attract more people to become front-line county mental health workers, and should provide these workers with an incentive to remain in that position long enough to develop a higher level of expertise and thereby provide improved services to persons with mental illness in the community. (p. 69)

schizophrenia, a major mood disorder, a psychotic disorder, schizoaffective disorder and borderline personality disorder.

Recommendation #12

The Pennsylvania Commission on Sentencing should explore the feasibility and advisability of adding offenders with mental illness to the category of “eligible offenders” under the county intermediate punishment provisions of the Judicial Code.³¹ (p. 83)

Recommendation #13

The Pennsylvania Commission on Crime and Delinquency should continue to provide assistance and guidance to the county criminal justice advisory boards (CJABS), to the end that the CJABs can assume a greater role in the coordination of pre-release planning and reentry coordination for inmates of county jails. (p. 84)

Recommendation #14

The Department of Public Welfare should issue new regulations governing ineligibility for Medical Assistance for inmates of correctional institutions to authorize suspension of benefits for those persons sentenced to less than one year of incarceration. (p. 85)

Recommendation #15

Amend 42 Pa.C.S. § 9764 to require county jails to provide inmates with mental illness who are being released upon completion of their maximum sentence with a 30 day supply of any psychotropic medication that is prescribed for the inmate. Smaller supplies may be given if there is a risk of overdose or if an outpatient psychiatric appointment has been scheduled to occur within the 30 day period. (p. 86)

Recommendation #16

The Mental Health and Intellectual Disability Act of 1966 (MH/ID Act)³² is almost 50 years old. When first enacted, it set forth commitment standards and procedures for both persons with mental illness and persons with intellectual disabilities. Easily half of the act has been superseded by the Mental Health Procedures Act. It is recommended that the MH/ID be reviewed, updated and codified as part of the Mental Health Code designated as Title 50 of the Pennsylvania Consolidated Statutes.

³¹ 42 Pa.C.S., Chapter 98 (relating to county intermediate punishment).

³² Act of October 20, 1966, Sp. Sess. 3 (P.L.96, No.6); 50 P.S.A. §4101 *et seq.*

LAWS GOVERNING THE MENTAL HEALTH SYSTEM AND TREATMENT OF PERSONS WITH MENTAL ILLNESS

Two principal acts govern the structure of the mental health system in Pennsylvania and the treatment of persons with mental illness. A few other ancillary statutes have an impact on the treatment of persons with mental illness in the Commonwealth.

Mental Health and Intellectual Disability Act of 1966

The Mental Health and Intellectual Disability Act of 1966 (MH/ID Act), consolidated the Commonwealth's authority to operate and maintain facilities for the care and treatment of persons with mental health concerns or intellectual disabilities in the Department of Public Welfare (DPW). It also mandates that local authorities of each county, separately or in concert, establish a county mental health and intellectual disability program for the prevention of mental disability and for the diagnosis, care, treatment, rehabilitation, and detention of mentally disabled persons.³³ The counties, in cooperation with DPW, are directed to ensure that the following services are available:

- Short-term inpatient services other than those provided by the Commonwealth.
- Outpatient services.
- Partial hospitalization services.
- 24-hour per day emergency services.
- Consultation and education services to professional personnel and community agencies.
- Aftercare services.
- Specialized rehabilitative and training services including sheltered workshops.
- Unified procedures for intake and a central referral and information service.

³³ *Ibid.*, at § 301, 50 P.S.A. § 4301.

Services may be provided directly or through contract/purchases. The provisions of the MH/ID Act that relate to admissions, commitments, and transfers between facilities are limited to those persons with intellectual disabilities, as The Mental Health Procedures Act (MHPA) repealed them as they relate to persons with mental illness.

Mental Health Procedures Act

The MHPA governs all *involuntary* inpatient and outpatient treatment, as well as *voluntary* inpatient treatment, of persons with mental illness.

Voluntary Treatment

Any person 14 years of age or older may voluntarily be admitted to a mental health facility for examination and treatment. Children under the age of 14 may be subject to examination and treatment upon request of a parent, guardian or person in loco parentis. Notice, and the ability to object to the examination and treatment, is provided to the parent, guardian or person in loco parentis of any minor who is at least 14 years of age but less than 18 years of age. When an individual consents to voluntary inpatient treatment, the individual also agrees to remain in treatment for a specified period of time not to exceed 72 hours after having given written notice of the intent to withdraw from treatment.

Civil Involuntary Examination and Treatment

A person may be involuntarily committed to inpatient treatment, partial hospitalization or outpatient treatment if found to be severely mentally disabled, which is defined as follows:

as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.³⁴

There are several levels of involuntary civil commitment, based on the time period involved, generally ranging from 120 hours to 180 days. In some cases involving criminal activity, an initial maximum commitment period of up to one year may be imposed.

Section 302 Emergency Examination and Treatment

Emergency examination and treatment may occur for a period not to exceed 120 hours. This level of commitment can be initiated as follows: upon certification by a physician; upon a warrant issued by a county mental health/intellectual disability administrator; upon a warrant issued by a county MH/ID administrator following application by a physician or other responsible party; or without a warrant by a physician, peace officer or other person authorized by the county administrator who personally

³⁴ *Supra* note 29, at §301, 50 P.S.A. § 7301.

observed conduct showing the need for the examination and who may take the person to an approved facility. A physician must examine the individual within two hours of arrival to determine if the individual is severely mentally disabled and in need of emergency treatment. The individual must be discharged after 120 hours unless admitted voluntarily to treatment or a certification for extended involuntary emergency treatment is filed pursuant to Section 303.

Section 303 Extended Involuntary Emergency Treatment

If the facility treating the person under Section 302 determines that the need for emergency treatment is likely to extend beyond 120 hours, an application can be made under Section 303 to continue treatment for up to an additional 20 days. An informal hearing, at which the person subject to the involuntary treatment must be represented by counsel, must be held by a court of common pleas judge or a mental health review officer to review the application of extended involuntary emergency treatment. If approved, the judge or mental health review officer must issue a certification of findings and a description of the treatment certified. Decisions of mental health review officers are subject to review by the court of common pleas upon petition of the person subject to the commitment proceedings. The individual must be discharged after 20 days unless he is admitted voluntarily to treatment or a petition for court-ordered involuntary treatment is granted under Section 304.

Section 304 Court-Ordered Involuntary Treatment

Court-ordered involuntary treatment may be sought for a person already subject to extended involuntary emergency treatment under Section 303, court-ordered involuntary treatment under Section 304, additional periods of court-ordered involuntary treatment under Section 305, and also for persons who are not currently receiving involuntary treatment. The county administrator or the director of the facility where the person is receiving treatment may petition the court of common pleas for court-ordered involuntary treatment for persons already subject to treatment under Sections 303, 304, and 305. Any responsible party can petition for Section 304 involuntary treatment for a person not already in treatment. The person must be represented by counsel, and a formal hearing is required. That hearing must take place within 5 days of the petition for persons who are already in involuntary treatment. Inpatient treatment, outpatient treatment, or a combination of both may be ordered by the court. Inpatient treatment should not be used unless less restrictive alternatives are considered and found inadequate. Generally, court-order involuntary treatment under Section 304 may last no longer than 90 days.

In a criminal case, the district attorney, the defendant, counsel for the defendant, the county administrator or any other interested party may petition the court for an order directing involuntary treatment under Section 304 for a person found incompetent to stand trial, lacking criminal responsibility or who was ordered to undergo an examination in aid of sentencing.³⁵ A person found incompetent to stand trial or acquitted because of lack of

³⁵ *Ibid.*, § 406, 50 P.S.A. § 7406.

criminal responsibility for certain crimes³⁶ can receive court-ordered involuntary treatment under Section 304 for up to one year.

Section 305 Additional Periods of Court-Ordered Involuntary Treatment

The county administrator or the director of the treatment facility may petition the court of common pleas for an additional period of treatment for a person under court-ordered involuntary treatment under Section 304 at the expiration of the original period ordered. Another hearing must be held and findings made. Generally, additional periods of involuntary treatment under Section 305 may last no longer than 180 days. Persons who are in treatment because they are considered a danger to self may be subject to Section 305 treatment only if first released to a less restrictive alternative unless a judge or mental health review officer determines that the release would not be in the person's best interest. A person found incompetent to stand trial or acquitted because of lack of criminal responsibility for certain crimes³⁷ can receive additional court-ordered involuntary treatment under Section 305 for up to an additional year.

Forensic Examination and Treatment

Forensic examination and treatment deals with persons with mental illness who are involved in the criminal justice system. It includes persons charged with a crime or under sentence who need mental health services, who are found incompetent to stand trial, and persons found not guilty by reason of insanity.

Persons Charged with a Crime or Serving Sentence

Section 401 of the MHPA provides that persons charged with a crime or serving a sentence who become severely mentally disabled may be subject to examination and treatment under the general civil provisions of the MHPA found in Sections 302, 303, 304 and 305. Similar provision is made for children who become seriously mentally disabled while subject to the Juvenile Act.³⁸ Provisions for the security of the individual will continue to be enforced. Persons charged with or convicted of certain violent crimes may be required by the court to be held under the security equivalent of that of the institution in which he was incarcerated.³⁹ Section 407 allows for voluntary treatment for persons charged with a crime or serving a sentence under certain conditions. This category also includes persons found guilty but mentally ill. Treatment that is psychiatrically or psychologically indicated may be provided by the DOC, by the county or by the DPW and is dependent upon the nature of the person's illness, security requirements and place of incarceration.⁴⁰ Children involved in the juvenile justice system who require mental health services may receive involuntary treatment under the provisions of the MHPA.⁴¹

³⁶Murder, voluntary manslaughter, aggravated assault, kidnapping, rape, involuntary deviate sexual intercourse or arson. *Ibid.*, § 304(g)(2). 50 P.S.A. § 7304(g)(2).

³⁷ *Ibid.*

³⁸ 42 Pa.C.S. Chapter 63.

³⁹ *Supra*, note 29 at § 401(b), 50 P.S.A. § 7401(b).

⁴⁰ 42 Pa.C.S. § 9727.

⁴¹ 42 Pa.C.S. § 6356.

Incompetent to Proceed on Criminal Charges

Under Section 402 of the MHPA, the court of common pleas may order an incompetency examination for a person who is charged with a crime and is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense so long as such incapacity exists. Persons who do not meet the standards of severe mental disability but are found to be incompetent to proceed may be ordered by the court to receive inpatient treatment, partial hospitalization, or outpatient treatment for a period of 60 days, if the court is reasonably certain that the treatment will provide the defendant with competency to stand trial. A hearing may be held on the court's initiative and must be held if the defendant or counsel objects to the competency examination. Provisions governing the hearing procedures are found in Section 403 of the MHPA.

Determination of Lack of Criminal Responsibility

If a hearing is held under Section 403 of the MHPA, the court may also hear evidence on whether the person was criminally responsible for the commission of the crime charged under Section 404. An acquittal order may be entered at that time or the defendant may raise the claim of lack of responsibility at trial.

Examination in Aid of Sentencing

The court may order an examination for mental illness to aid in sentencing under Section 405 of the MHPA upon the court's own initiative, or application by the person charged, his counsel or any other person acting in his interest.

Other Pennsylvania Laws

Continuity of Care

The Consumers' Continuity of Care Act⁴² authorizes hospitals to grant clinical privileges to licensed professional psychologists and add them to their professional staff. When an individual is admitted to a hospital for inpatient psychiatric treatment, the attending physician is required to make reasonable attempts to identify the patient's outpatient treating psychologist and notify the psychologist of the individual's admission. Any patient's treating psychologist may confer with the attending physician to facilitate the initial treatment plan and establish the patient's baseline status, and, with patient consent, the attending physician may maintain communication with, and provide notice prior to or at discharge to, the treating psychologist. Additionally, if the patient's treating psychologist is credentialed by the admitting hospital, the psychologist may also attend and participate in treatment team meetings during the person's hospitalization.

⁴² Act of October 3, 2003 (P.L. 177, No. 28); 50 P.S.A. § 9001 *et seq.*

Administrative Statutes

The Administrative Code of 1929 assigned the licensing and regulation of mental health institutions to the Department of Public Welfare.⁴³ The Public Welfare Code establishes DPW's duties relative to mental health, provides for the appointment of the Commissioner of Mental Health and enacts the Interstate Compact on Mental Health, which addresses reciprocal agreements with other states regarding transfer of patients.⁴⁴

In 1999, the Mental Health or Mental Retardation Facility Closure Act was enacted. This act requires DPW to hold a public hearing in the county where a state-operated facility is located, when DPW announces the closure of the facility or a reduction in patient census or staff complement of 20 percent or more.⁴⁵

Advance Directive for Mental Health/Mental Health Power of Attorney

In 2004 the Pennsylvania General Assembly added a new Chapter 58 (Mental Health Care) to Title 20 of the Pennsylvania Consolidated Statutes. Under this chapter, an individual may prepare an advance directive for mental health that instructs medical personnel on the individual's preferences for mental health treatment should the individual become incapable, by reason of mental illness, to decide on his or her own. An individual may also execute a mental health power of attorney that designates a mental health care agent to make mental health care decisions on his or her behalf. Decision-making powers may include preference for a treatment facility, consent or refusal of certain types of treatment, dietary restrictions, religious preferences, temporary custody of children, and family notification. While these directives can provide guidance to others, not all aspects are legally binding, and they are treated as simply advisory.

Proposed Legislation, 2013-2014

Several pieces of legislation have been introduced during the 2013-2014 legislative session of the Pennsylvania General Assembly have an impact on the mental health system in Pennsylvania and on the MHPA.

⁴³ Act of April 9, 1929 (P.L.177, No. 175), § 2313; 71 P.S.A. § 603.

⁴⁴ Act of June 13, 1967 (P.L.31, No. 21), §§ 1101, 1111.1, 1121 *et seq.* and 1131; 62 P.S.A. §§ 1101, 1111.1, 1121 *et seq.*, 1131.

⁴⁵ Act of April 28, 1999 (P.L.24, No.3), 50 P.S.A. § 8001 *et seq.*

Table 1
Pennsylvania General Assembly
Proposed Legislation Affecting Mental Health Laws, 2013-2014

Bill No.	Summary	Status
HB550, P.N.605	Establishes court-ordered assisted outpatient treatment procedures under the MHPA. See also SB 77, P.N.42, referred to S. Public Health and Welfare Cmte. Jan. 9, 2013	Referred to H. Human Services Cmte. Feb. 6, 2013
HB1011, P.N.2024	Prohibits the use of State funds appropriated to the Department of Corrections to privatize or outsource psychological services at state correctional institutions. See also SB1025, P.N.1274, referred to S. Judiciary Cmte. June 24, 2013	Referred to H. Judiciary Cmte. June 12, 2013
HB1019, P.N.1205	Establishes the Office of Veterans' Mental Health Awareness in the Department of Military and Veterans' Affairs – to coordinate and support services to veterans with mental illness, mental disability and trauma	Referred to H. Veterans Affairs and Emergency Preparedness Cmte. March 18, 2013
HB1449, P.N.1877	Requires licensing boards under the Department of State that impose a continuing education credit to grant credit for Mental Health First Aid USA training	Referred to H. Professional Licensure Cmte., May 28, 2013
HB1504, P.N.2068	Amends Titles 42 and 53 to require education and training on mental illness and diversionary programs for members of the minor judiciary and municipal police officers	Passed House (195-0) Oct. 1, 2013; re-referred to S. Appropriations Cmte. Dec. 4, 2013
HB1557, P.N.2094	Establishes a student loan forgiveness program to be administered by PHEAA for community mental health, intellectual disability or drug and alcohol staff members.	Referred to H. Human Services Cmte. June 19, 2013
HB1799, P.N.2587	Provides for departure from mandatory sentencing for persons who have been diagnosed with a recognized mental illness	Referred to H. Judiciary Cmte. Oct. 23, 2013
HB1889, P.N.2757	Authorizes courts of common pleas to establish mental health court divisions using grants from the Administrative Office of Pennsylvania Courts	Referred to H. Judiciary Cmte., Dec. 9, 2013
SB128, P.N.1205	Codifies the Pennsylvania Commission on Crime and Delinquency's Mental Health and Justice Systems Advisory Committee as the Mental Health and Justice Advisory Committee. To advise PCCD on program development and administration of the Mental Health and Justice grant program to improve services to persons with mental illness who are at risk of involvement in the juvenile or criminal justice systems	First consideration June 11, 2013; re-referred to S. Appropriations Cmte. June 25, 2013
SB190, P.N.137	Amends the MHPA to allow disclosure of confidential medical records for firearms purchase background check purposes	Referred to S. Judiciary Cmte. Jan. 17, 2013
SB488, P.N.451	Abolishes the common law defense of insanity	Referred to S. Judiciary Cmte. Feb. 13, 2013
SB796, P.N.827	Amends the MHPA to eliminate the need to demonstrate that a person has committed acts in furtherance of a threat of harm to self or others - permits an examination of the totality of the circumstances to determine clear and present danger. History of treatment and diagnosis, and past behavior can be considered. Removes "bodily" from the threat of harm to others and removes "physical" from the threat of serious debilitation in danger to self	Referred to S. Public Health and Welfare Cmte. April 3, 2013

THE MENTAL HEALTH DELIVERY SYSTEM

Pennsylvania's mental health system is directed at the State level through the Office of Mental Health and Substance Abuse Services (OMHSAS) within the Department of Public Welfare (DPW). Four Regional Mental Health/Substance Abuse Field Offices⁴⁶ support 48 county mental health/intellectual disability programs. Additionally, DPW operates six state psychiatric hospitals for inpatient psychiatric care of persons who have serious mental illness.⁴⁷

The Pennsylvania Department of Public Welfare

OMHSAS is under the direction of the Deputy Secretary for Mental Health/Substance Abuse Services. Assisting the deputy secretary is the Medical Director for Mental Health/Substance Abuse Services, who serves as the chief medical officer of the state mental hospital system and provides oversight to community services as the chief clinical officer. The Medical Director supervises the Division of Clinical Review and Consultation and the Emergency Behavioral Health Preparedness, Response and Recovery Program. The emergency program consists of county and state behavioral health initiatives designed to help persons prepare for, respond to and cope with the psychosocial and emotional consequences of disasters and public health emergencies.

Within OMHSAS, there are five bureaus dedicated to specific topics. A brief description of each bureau is set forth below:

- The Bureau of Children's Behavioral Health Services supports children with serious behavioral and emotional challenges and their families. Specific groups of children are targeted, including those in the child welfare system, in or at risk of entering the juvenile justice system, in the drug and alcohol system, with fetal alcohol spectrum disorder, who are deaf or hard-of-hearing, with traumatic brain injury, with autism spectrum disorder or other pervasive developmental disorder, with physical disability, and at risk for suicide.
- The Bureau of Community and Hospital Operations is divided into three Divisions – Eastern, Western and Hospital Operations. The four regional mental health/substance abuse field offices are divided between

⁴⁶ Central Field Office (Harrisburg), Northeast Field Office (Scranton), Southeast Field Office (Norristown) and Southwest Field Office (Pittsburgh).

⁴⁷ Clarks Summit State Hospital, Danville State Hospital, Norristown State Hospital, Torrance State Hospital, Warren State Hospital and Wernersville State Hospital.

the Division of Eastern Operations and the Division of Western Operations. The Bureau is responsible for oversight of the county mental health programs and the behavioral health program component of Pennsylvania's mandatory Medicaid managed care program (HealthChoices), along with operation and oversight of the state hospital system and South Mountain Restoration Center (the Commonwealth's long-term care facility).

- The Bureau of Policy and Program Development consists of three divisions. The Division of Planning and Policy Development deals with regulatory and legislative mandates, county plan guidelines and review criteria, and design and redesign of programs. Additionally, the bureau establishes program standards and supplies technical assistance on best practices and model programs. The Division of Research and Program Development is responsible for the planning and provision of the medical assistance behavioral health program. The Division of Substance Abuse Services supervises services for individuals with co-occurring mental health and substance use disorders.
- The Bureau of Quality Management and Data Review consists of two divisions. The Division of Quality Management monitors and evaluates the quality of care and services of behavioral health programs within the Commonwealth. The Division of Systems Management and Data Review maintains data of services provided, outcomes and costs.
- The Bureau of Financial Management and Administration consists of two divisions; the Division of Budget and Administrative Services, and the Division of Medicaid Finance.

State Hospital System

Pennsylvania's six state psychiatric hospitals are geographically dispersed around the Commonwealth in the Northeast (Clarks Summit), Northern Central (Danville), Southeast (Norristown), Southwest (Torrance), Northwest (Warren), and Southern Central (Wernersville) regions. Each hospital provides long-term inpatient psychiatric care and only accept referrals of patients who are already inpatient at a community psychiatric facility.

Intended to serve only persons with serious mental illness, it is not surprising that on June 30, 2013, 73 percent of the persons served in the state hospital system had an Axis I diagnosis of schizophrenia and related psychotic disorders (1,136 persons out of 1,530).⁴⁸ As of that same date, six individuals with schizophrenia and related psychotic disorders

⁴⁸ Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare, "Pennsylvania State Hospital System Length-of-Stay, Demographics & Diagnoses Report for June 30, 2013," <http://www.dpw.state.pa.us/foradults/statehospitals/>.

had been in residence for over 50 years in the state hospital system; no other diagnosis resulted in a length of stay longer than 25 years.⁴⁹ At the other extreme, 142 individuals out of a total of 205 had been in residence for less than six months with a schizophrenia/psychosis diagnosis. The largest group by years of residence was the group of individuals who had been in residence less than 20 years, and even within that group, over 76 percent of those persons met the schizophrenia/psychosis diagnosis.⁵⁰

Clarks Summit State Hospital

Clarks Summit State Hospital is an extended acute care psychiatric hospital serving 11 counties in the northeastern part of Pennsylvania. The facility is located approximately eight miles north of the city of Scranton in a suburban setting. The hospital's service area encompasses the following counties: Bradford, Carbon, Lackawanna, Luzerne, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming. On March 25, 2014, DPW was scheduled to hold a public hearing in Scranton because of declining patient population pursuant to the Mental Health or Mental Retardation Facility Closure Act.⁵¹

Danville State Hospital

Danville State Hospital is long-term care psychiatric facility serving 17 counties in the northern central part of Pennsylvania. The hospital's service area encompasses the following counties: Columbia, Centre, Clinton, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lycoming, Mifflin, Montour, Northumberland, Perry, Schuylkill, Snyder and Union Counties.

Norristown State Hospital

Norristown State Hospital is a psychiatric facility serving the five counties of the Southeastern region of Pennsylvania: Bucks, Chester, Delaware, Montgomery and Philadelphia. The facility has 258 beds for individuals in General Psychiatry (Civil Section) and 136 beds for individuals in The Regional Psychiatric Forensic Unit.⁵²

Torrance State Hospital

Torrance State Hospital provides inpatient services for individuals with severe and persistent mental illness in 10 counties in the southwestern region of Pennsylvania. The hospital's service area for civil commitments includes the following counties: Allegheny, Armstrong, Bedford, Blair, Butler, Cambria, Fayette, Indiana, Somerset and Westmoreland Counties. The hospital offers three distinct services: Civil; the Regional Forensic

⁴⁹ These geriatric patients are dispersed throughout the state hospital system, with 22 at Wernersville, 21 at Norristown, 14 at Clarks Summit, 13 at Danville, 13 at Warren and 9 at Torrance.

⁵⁰ *Supra*, note 48.

⁵¹ Pennsylvania Department of Public Welfare, Press Release, "Department of Public Welfare to Hold Public Hearing on Declining Patient Population at Clarks Summit State Hospital," February 25, 2014.

⁵² For further discussion of the Norristown regional forensic unit, see the chapter entitled "Persons with Mental Illness in the Criminal Justice System," *infra*.

Psychiatric Center (RFPC), and the Sexual Responsibility and Treatment Program (SRTP).⁵³

Warren State Hospital

Warren State Hospital provides inpatient hospitalization for 13 counties in the northwestern region of the Commonwealth. The hospital's service area includes the following counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren Counties. Warren State Hospital offers specialized programs for individuals whose conditions are complicated by the aging process, posttraumatic brain injury, or other serious neurological impairments.

Wernersville State Hospital

Wernersville State Hospital provides inpatient hospitalization for seven counties in the south central and eastern regions of the Commonwealth. The hospital's service area includes the following counties: Adams, Berks, Lancaster, Lebanon, Lehigh, Northampton and York Counties.

South Mountain Restoration Center

Originally established as a tuberculosis sanatorium in 1901, South Mountain Restoration Center was transformed into a 159 bed long-term care facility in 1968. Located in Franklin County near Caledonia State Park and Michaux State Forest, it provides care to persons who have histories of serious psychiatric illness, persons who have lived for many years in state centers and persons who have been incarcerated. Residents of the Center have exhausted other alternatives for placement, are psychiatrically stable and do not exhibit behaviors that would put themselves or other residents at risk of harm. Accordingly, the Center restricts the admission of residents with active psychosis, substance abuse problems or combative behavior. All new residents must be certified by the Area Agency on Aging as needing nursing home care.

Olmstead Plan

In 1999, the United States Supreme Court ruled that individuals with disabilities, including mental illness, had the right to receive care in the most integrated setting appropriate and that unnecessary institutionalization was discriminatory and violated the Americans With Disability Act (ADA).⁵⁴ This decision, known as the Olmstead ruling,⁵⁵ provides that states must ensure that Medicaid-eligible persons do not experience discrimination by being institutionalized when they could be served in a more integrated setting. One of the court's recommendations was that states demonstrate compliance with the ADA by producing formal plans for increasing community integration. Pennsylvania

⁵³ For further discussion of the Torrance RFPC and SRTP, see the chapter entitled "Persons with Mental Illness in the Criminal Justice System," *infra*.

⁵⁴ Pub. L. 101-336, 42 U.S.C. § 12101 et seq.

⁵⁵ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

first issued its State Mental Health Olmstead Plan in 2011 and updated the plan in August 2013. The plan priorities are to return individuals residing in state psychiatric hospital units to a community of their choice, provide individuals residing in other institutions or large segregated and/or congregated settings the opportunity to live in more integrated settings, and divert individuals from institutions and large segregated congregate settings.⁵⁶

As part of the updated plan, DPW expects to reduce state hospital civil bed capacity by closing at least 90 state hospital beds each fiscal year through discharge of hospital residents. DPW will continue its efforts to consolidate and close state hospitals, although it is estimated that 5 to 7 percent of the 2013 population in the civil sections of the state hospitals may require supervised, structured settings because of clinical or criminal histories.⁵⁷ Funds saved by those closures will be provided to the counties through the Community Hospital Integration Project Program (CHIPP)⁵⁸ to develop community supports and services for persons discharged from the state hospitals. Counties are encouraged to transform existing services and programs to more evidence-based programs. Services should include:

- Prevention and early intervention.
- Non-institutional housing options, including “Housing First” models that do not mandate that consumers participate in other services or programs.
- Non-residential treatment services and community supports, such as mobile treatment options, case management, extended acute care centers, psychiatric rehabilitation services, medication management, mobile crisis services, and employment opportunities.
- Peer support and peer-run services, such as certified peer specialists, and drop-in centers.⁵⁹

County Mental Health/Intellectual Disability Programs

Mental health services are primarily delivered at the county level through the county mental health/intellectual disability programs. Pennsylvania’s 67 counties are served by 48 programs. Services include vocational/employment services, psychiatric rehabilitation services, community treatment teams, housing supports, consumer-run drop-in centers, social/recreational services and other locally designed services.

⁵⁶ Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, “Updated Olmstead Plan For Pennsylvania’s State Mental Health System,” August 2013, at page 6.

⁵⁷ *Ibid.*, at page 10.

⁵⁸ See discussion of CHIPP at page 49, *infra*.

⁵⁹ *Supra*, note 56 at page 11.

Table 2
County Mental Health/Intellectual Disability Programs

Program Name	Location
Allegheny County Department of Human Services	Pittsburgh
Armstrong/Indiana Behavioral & Developmental Health Program	Kittanning
Beaver County Behavioral Health	Beaver Falls
Bedford/Somerset MH/MR	Somerset
Berks County MH/DD	Reading
Blair County MH/BH/ID Programs	Hollidaysburg
Bradford/Sullivan MH/MR	Towanda
Bucks County Department of Mental Health/Developmental Programs	Warminster
Butler County MH/EI/ID Program	Butler
Cambria County Behavioral Health/Intellectual Disability Program	Johnstown
Cameron/Elk Counties Behavioral & Development Programs	Ridgway
Carbon-Monroe-Pike MH/DS	Stroudsburg
Centre County MH/ID/EI	Bellefonte
Chester County Department of Mental Health/Intellectual & Developmental Disabilities	West Chester
Clarion County MH/DD	Clarion
CMSU Behavioral & Developmental Services (Columbia, Montour, Snyder and Union Counties)	Danville
Community Connections of Clearfield/Jefferson Counties	Dubois
Crawford County Intellectual Disabilities Program	Meadville
Cumberland/Perry MH/IDD	Carlisle
Dauphin County Mental Health/Intellectual Disabilities Program	Harrisburg
Delaware County BH/ID	Upper Darby
Erie County MH/MR	Erie
Fayette County Behavioral Health Administration	Uniontown
Forest/Warren Human Services	Warren
Franklin/Fulton MH/ID/EI	Chambersburg
Greene County Human Services	Waynesburg
Juniata Valley Behavioral & Developmental Services	Lewistown
Lackawanna/Susquehanna BH/ID/EI Programs	Scranton
Lancaster County BH/DS	Lancaster
Lawrence County Mental Health & Developmental Services	New Castle
Lebanon County MH/ID/EI	Lebanon
Lehigh County MH/ID/D&A/EI	Allentown
Luzerne/Wyoming MH/Developmental Services Program	Wilkes-Barre
Lycoming/Clinton MH/ID	Williamsport
McKean County MH/MR	Smethport
Mercer County MH/DS	Mercer
Montgomery County Department of Behavioral Services/Developmental Disabilities	Norristown
Northampton County MH/EI/Developmental Programs Division	Bethlehem
Northumberland County BH/ID Services	Sunbury
Philadelphia Department of Behavioral Health & Intellectual Disability Services	Philadelphia
Potter County Human Services	Roulette
Schuylkill County Administrative Offices of MH/DS/D&A	Pottsville
Tioga County Department of Human Services	Wellsboro
Venango County Mental Health & Developmental Services	Franklin
Washington County BH/DS	Washington
Wayne County Office of Behavioral & Developmental Programs/EI	Honesdale
Westmoreland County Behavioral Health & Developmental Services	Greensburg
York/Adams MH/IDD	York

County MH/ID programs administer the local program, provide information and referral, consultation and education, case management, and early intervention for young children. They may be direct service providers and offer a variety of mental health services, or they may contract with various social services agencies within each county to provide services.⁶⁰ The following services can be found in most counties across the Commonwealth:

- Inpatient.⁶¹
- Outpatient.
- Partial hospitalization.
- Day treatment.
- Community residential programs/rehabilitation.
- Crisis intervention.
- Emergency services.
- Respite care.
- Vocational rehabilitation.
- Social rehabilitation.
- Job placement.
- Sheltered workshops.
- Advocacy.
- Support groups.
- Supportive living services.
- Representative payee programs.
- Consumer drop-in centers.

⁶⁰ Information on county services compiled from each county's Resource Directory. County resource directories can be found online at http://www.portal.state.pa.us/portal/serv.pt/directory/resource_guides/155964?DirMode=1. In most cases, the directories were last updated or revised in the spring of 2011.

⁶¹ Shorter-term inpatient psychiatric services are usually provided by counties through contracts with local hospitals that maintain psychiatric units within the hospital or private psychiatric hospitals.

A number of counties offer specialized programs. A sampling includes:

- Housing for men with mental illness (Allegheny).
- Housing for single parents with a mental health disability and with primary physical custody of children (Allegheny).
- Housing for mental health consumers on probation (Beaver).
- Forensic program (Berks).
- Homeless shelter for persons with serious mental illness (Erie).
- Housing support for low-income persons with mental illness (Jefferson).
- Apartment living for adults with mental illness (Lebanon).
- Mental health evaluations for male non-violent ex-offenders on probation or parole with a history of substance abuse (Northampton).
- Community of formerly homeless single women with serious mental illness (Philadelphia).
- Residential treatment program for women who have a substance abuse and a mental health diagnosis and are either pregnant or have no more than two children (Philadelphia).
- Residential treatment facilities for homeless persons with mental illness (Wayne).

Evidence-Based Practices

Both the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services and OMHSAS support and encourage the use and development of evidence-based practices for community mental health services programs. OMHSAS has encouraged Pennsylvania counties to develop evidence-based practices to promote recovery and resiliency for persons with mental illness. The term “evidence-based practices” refers to the use of behavioral health interventions for which systemic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.⁶²

⁶² Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, “Transformation Through Planned Partnerships: A Summary Report of the Fiscal Year 2010-

Assertive Community Treatment provides close supervision and assistance for those persons with the most serious mental illnesses who otherwise might not be able to function in society, resulting in an inpatient hospitalization or incarceration. Family psychoeducation, supported housing, and supported employment help provide the stability and normalcy that persons with mental illness desire; they also help maintain the mental equilibrium of such persons.

Illness management and recovery, together with MedTEAM (Medication, Treatment, Evaluation and Management) allow persons with mental illness to more fully participate in making treatment decisions, especially with regard to the use of psychotropic drugs. Psychotropic drugs have made the closure of state mental hospitals possible and allows many people who would have required inpatient hospitalization to function in the community. However, many of these drugs come with serious side effects, such as major weight gain and metabolic changes, increasing the risk of diabetes and high cholesterol, blackouts, seizures, blurred speech, rapid or irregular heartbeat, reproductive disorders in girls and women, and suicidal ideation. Further, long-term use may lead to tardive dyskinesia, a sometimes permanent set of involuntary muscle movements, most commonly occurring around the mouth. MedTEAM allows a prescriber and a person with mental illness to fully explore the person's history of responses to other medications and potential side effects in order to make an informed decision as to which medication will be effective for the person. Further, the person with mental illness, given the opportunity to participate and consent to medication, is more likely to comply with the prescription.⁶³

In 2009, the 48 county mental health/intellectual disability programs reported the use of the several evidence-based practices within their programs.⁶⁴ The list below indicates how many of the 48 programs have these services. These numbers may not be completely accurate, as some counties reported that they have reduced or eliminated a number of programs due to budgetary issues in 2012-2013.⁶⁵

- Assertive Community Treatment (18).
- Supported Employment (34).
- Supported Housing (33).
- Family Psychoeducation (16).
- Integrated Treatment of Co-occurring Disorder (13).
- Illness Management/Recovery (24).
- Medication Management (18).

2011 County Mental Health Plans for Adults, Older Adults, & Transition-Age Youth with Serious Mental Illness and Co-occurring Disorders,” November 2010, at p. 5.

⁶³ National Institute of Mental Health, National Institutes of Health, “Introduction: Mental Health Medications,” <http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml>.

⁶⁴ *Supra*, note 62.

⁶⁵ *Supra*, note 26.

An important aspect of evidence-based practices is maintaining fidelity to the model. This requires adherence to specific programmatic standards and principles. When implementing evidence-based practices, fidelity issues must be addressed, such as how fidelity will be ensured, how providers will be trained, and how providers will be held accountable for correct implementation of the practice.⁶⁶

Assertive Community Treatment

Assertive Community Treatment (ACT), also referred to as Community Treatment Teams (CTT), is a comprehensive community-based model for delivering treatment, support, and rehabilitation to those individuals with the most intractable symptoms of serious mental illness and the greatest level of functional impairment who would otherwise rely heavily on inpatient psychiatric services. The model consists of 10-12 professionals who provide the specific mix of services needed by the individual consumer. It is available 24 hours a day, 7 days a week, on an ongoing basis, and is mobile, going to the consumer rather than requiring the consumer to come to the program.⁶⁷ The ACT program has been estimated to cost between \$10,000 to \$15,000 per person per year based on a team of 10-12 people and a 1 to 10 staff-to-consumer ratio.⁶⁸

Fidelity to the model is extremely important, and Pennsylvania requires adherence to the Dartmouth Assertive Community Treatment Fidelity Scale (DACTS). “The approach with each consumer emphasizes relationship building and active involvement in assisting individuals with serious mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.”⁶⁹

There are 42 ACT/CTT programs operating in Pennsylvania. OMHSAS piloted a standard statewide licensing tool that is being used to license ACTs across the Commonwealth. As of March 2013, 30 of 42 teams had been licensed.⁷⁰ Full-size teams in urban areas include 10-12 clinical staff members plus a psychiatrist and a program assistant. Staff to consumer ratios are 1 to 10 (not including the psychiatrist and program assistant). Similar rules apply to modified teams that serve rural areas, but teams include 6-8 clinical staff members and a ratio of 1 to 8.⁷¹

⁶⁶ Joel E. Miller, “Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities,” National Association of State Mental Health Program Directors Report, 2012, <http://www.nasmhpd.org/publications/NASMHPDPublications.aspx>, at pages 46-47.

⁶⁷ Substance Abuse and Mental Health Services Administration. “Assertive Community Treatment: The Evidence,” DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2008.

⁶⁸ National Alliance on Mental Illness Fact Sheet, “Assertive Community Treatment: Investment Yields Outcomes,” September 2007, www.nami.org.

⁶⁹ Mental Health and Substance Abuse Services Bulletin, Department of Public Welfare, Commonwealth of Pennsylvania, “Assertive Community Treatment (ACT),” OMHSAS-08-3, September 2, 2008.

⁷⁰ Department of Public Welfare, Commonwealth of Pennsylvania, “Community Mental Health Service Block Grant – Fiscal Year 2014-2015,” at page 22, <http://www.dpw.state.pa.us/provider/mentalhealth/>.

⁷¹ “Statewide Initiatives: Assertive Community Treatment,” Pennsylvania Recovery and Resiliency, www.parecovery.org/services.act.shtml. ACT/CTT providers are located in the following county programs: Allegheny, Beaver, Berks, Bucks, Carbon/Monroe/Pike, Chester, Cumberland/Perry, Dauphin, Delaware,

Similar to ACT and CTT is mobile mental health treatment (MMHT), designed to assist those individuals who meet one of two criteria: (1) the person meets the medical necessity guidelines for psychiatric outpatient services and has a medical or psychiatric condition that impairs the ability to participate in psychiatric outpatient services; or (2) the person has one or more psychosocial stressors that impair the ability to participate, or preclude participation, in psychiatric outpatient clinic services. MMHT includes evaluation and treatment, including individual, group and family therapy as well as medication visits in an individual's residence or other community-based settings.⁷²

Supported Employment

Supported employment permits person with mental illness to work in jobs they prefer with the level of professional assistance that they need. Several key elements are required for a program to be successful. A commitment on the part of county programs treating competitive employment as an attainable goal, rather than day treatment or sheltered work, is crucial. Supported employment programs must use a rapid and direct approach to assisting consumers in job searching. Job placements should be sought according to consumer preferences, strengths, and work experiences. Follow-along supports should be maintained indefinitely. The supported employment program must be closely integrated with the mental health treatment team.⁷³

Four county programs (Allegheny, Beaver, Cumberland/Perry and Montgomery) have implemented supported employment through OMHSAS' Employment Transformation Project. The Bucks, Delaware, Franklin/Fulton and Northampton county programs have received training, and are making efforts to increase knowledge of employment in their counties.

Two other programs found in Pennsylvania that support employment are Fairweather Lodges and Clubhouses. A Fairweather Lodge is a group of four to eight people who share a house and own a small business. Each group selects a business to operate and develops and implements a business plan. Pennsylvania currently has 35 lodges with an additional 20 in development. Businesses include transportation, Medicaid-funded peer supports, lawn care, custodial or laundry services, printing, furniture building, shoe repair, catering, and other services.⁷⁴

Clubhouse is a community based social and vocational rehabilitation program. Work and clubhouse membership are the primary methods of providing increased opportunities for employment, housing, education, skill development, and social activities. There are currently 24 programs in Pennsylvania, 19 of which are certified with regard to

Erie, Fayette, Greene, Lancaster, Lebanon, Lehigh/Northampton, Montgomery, Philadelphia, Washington, Westmoreland, and York.

⁷² *Supra*, note 70 at page 32.

⁷³ Substance Abuse and Mental Health Services Administration. "Supported Employment: Building Your Program," HHS Pub. No. SMA-08-4364, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2009.

⁷⁴ *Supra*, note 70 at pages 23-24.

fidelity principles and 14 of those 19 are licensed by OMHSAS. OMHSAS's goal is to have all clubhouses certified and licensed.

Supported Housing

Permanent supportive housing is designed to address homelessness among persons with psychiatric disabilities, and is a grant program of the U.S. Department of Housing and Urban Development. Two key elements of the programs are important: (1) tenants have a lease in their name and have full rights under landlord-tenant law, including control over living space and protection against eviction; and (2) leases do not have any provisions that would be found in a lease held by someone who does not have a psychiatric disability.⁷⁵

In Pennsylvania, the Permanent Supportive Housing Initiative is an OMHSAS-implemented program designed to enable consumers to make informed decisions about their own housing and retain more of their income by living in integrated settings, including shared housing, in which three or fewer consumers are living in a single family dwelling or rental unit. Fifty-three counties have made funds available for this initiative, which allows counties to invest in several interconnected housing strategies – investment in development projects, project-based operating assistance using tax credit developments, short-term bridge rental assistance, master leasing for consumers with criminal records or poor tenancy histories, a housing clearinghouse, housing support services, and contingency funds, such as security deposits or bank rent payments.⁷⁶

The Allegheny County Office of Behavioral Health has created a permanent supported housing program designed to “benefit the entire Allegheny County community through more appropriate and efficient use of resources to support high-priority consumers with serious mental illnesses and co-occurring disorders by reducing their reliance on hospital, emergency shelter and criminal justice resources.”⁷⁷

Pennsylvania Housing Choices is a website sponsored by OMHSAS and administered by Diana T. Myers and Associates, Inc. The website provides information about housing programs and opportunities for people with mental illness and co-occurring disorders. This website is targeted to county mental health housing specialists, other county mental health personnel, peer support specialists, family members and people with mental illness, providers, state officials, public housing authorities, developers, advocates, and others interested in housing for people with disabilities.⁷⁸

⁷⁵ Substance Abuse and Mental Health Services Administration. “Understanding Permanent Supportive Housing: Building Your Program,” HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2010.

⁷⁶ *Supra*, note 70 at pages 119-120.

⁷⁷ *Supra*, note 75, at Appendix D, page 121.

⁷⁸ See www.pahousingchoices.org.

OMHSAS has been providing technical assistance and training in housing for the county offices since the early 1990s. In 2001, a unique type of collaboration known as Local Housing Options Teams or LHOTs (pronounced L-HOTs) emerged. These are coalitions that bring together the key stakeholders on the county or multi-county level in order to identify local housing needs for people with disabilities, expand housing options, and seek long-term solutions to the housing needs of people with disabilities.⁷⁹ LHOTs are part of the Commonwealth's strategy to promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse, or co-occurring disorders. Fifty-five counties have LHOTs in place.⁸⁰

Family Psychoeducation

Family psychoeducation has been shown to reduce relapse rates and enable recovery of those with mental illness, particularly persons with schizophrenia. Other illnesses in which it has been found to be effective include bipolar disorder, major depression, obsessive-compulsive disorder, and borderline personality disorder. It has not been widely implemented statewide or nationwide, for a variety of reasons. It requires the expenditure of effort by both consumers and their family members and is time-consuming. In addition, it is most effective if individuals participate for at least three months. Consumers are often concerned about loss of autonomy and confidentiality. The program requires participation by providers and reimbursement by insurers and counties.⁸¹ Sixteen of Pennsylvania's 44 county programs have reported the existence of such services in their programs.⁸²

Integrated Treatment of Co-occurring Disorder

Co-occurring disorder programs combine mental health and substance abuse interventions. The critical components of effective programs include a comprehensive, long-term, staged approach to recovery, assertive outreach, motivational interventions, provision of help to consumers in acquiring skills and supports to manage both illnesses and to pursue functional goals, and cultural sensitivity and competence. One barrier to implementation of integrated treatment of co-occurring disorders is that responsibility for programs rests within different administrative departments.⁸³

⁷⁹ Pa Housing Choices, <http://www.pahousingchoices.org/housing-resources/local-housing-options-teams/>

⁸⁰ *Supra*, note 70 at pages 50-51.

⁸¹ Substance Abuse and Mental Health Services Administration. "Family Psychoeducation: The Evidence," HHS Pub. No. SMA-09-4422, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2009.

⁸² *Supra*, note 62.

⁸³ Substance Abuse and Mental Health Services Administration. "Integrated Treatment for Co-Occurring Disorders: The Evidence," HHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2009.

In Pennsylvania, DPW and the Department of Drug and Alcohol Programs (DDAP) have some overlapping responsibilities. Prior to the establishment of DDAP, DPW and the Department of Health (DOH) Division of Drug and Alcohol Program Licensure had begun to develop ways in which integrated treatment could be delivered to persons with mental illness and a co-occurring substance abuse disorder. In conjunction with Drexel University, DPW developed a training program for clinical professionals to be certified as competent in both fields. Over 1,000 behavioral health specialists have received a co-occurring competency based-credential that allows them to provide both mental health services and substance abuse counseling.

Under current law, facilities that wish to provide both mental health services and substance abuse services must be dually licensed by both DPW and DDAP.⁸⁴ In 2006, DPW and DOH issued a joint bulletin that provided a framework for certification of facilities in co-occurring disorder competency.⁸⁵ Fifteen programs have obtained certification for their facilities, and under the bulletin, they may provide all services, except active drug and alcohol treatment.⁸⁶ DDAP and DPW are working closely together to streamline the licensing process for these facilities. Other modes of delivery integrated services are also being developed. Under the assertive community treatment rules, 90 percent of the clinical services provided must come from a multi-disciplinary team that includes a substance abuse counselor. Certified peer specialists and certified recovery specialists can also help address the needs of persons with co-occurring disorders.⁸⁷

Illness Management/Recovery

Illness management and recovery can be an effective tool; it uses several component services to achieve its goals. Illness management teaches people and their families about their illnesses in order to improve adherence to recommended treatments and to manage or relieve persistent symptoms and treatment side effects. Recovery focuses not only on relief from symptoms, but also on social success and personal accomplishment in areas that the person considers important and helps prevent relapses. Illness management and recovery integrates three types of programs: psychoeducation, relapse prevention, and coping skills training.⁸⁸

⁸⁴ Telephone conference with OMHSAS staff, April 9, 2014.

⁸⁵ Bulletin, Department of Public Welfare and Department of Health, Commonwealth of Pennsylvania, "Co-Occurring Disorder Competency Approval Criteria for All Facilities Licensed by the Department of Health, Division of Drug and Alcohol Program Licensure, or the Department of Public Welfare, Office of Mental Health and Substance Abuse Services," OMSHAS-06-03, February 10, 2006 and OMHSAS 06-03 Interpretive Guidelines, May 24, 2007.

⁸⁶ Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, "Supporting the Journey: Transforming Pennsylvania's Behavioral Health System," 2010 at pages 52-53.

⁸⁷ *Supra*, note 69.

⁸⁸ Substance Abuse and Mental Health Services Administration. "Illness Management and Recovery: The Evidence," HHS Pub. No. SMA-09-4548, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2009.

Medication Management

MedTEAM offers medication management to people with serious mental illness. Four factors are involved in a successful MedTEAM: prescribers must know the best current evidence from systemic research; prescribers must integrate that information with their own clinical expertise; prescribers must be aware of consumers' experience and be able to integrate that experience into medication decisions; and medication management should be based on active consumer participation, mutual communication, and shared decisionmaking.⁸⁹

Peer Support Specialists

In conjunction with the Temple University Collaborative on Community Inclusion, OMHSAS is developing curricula for enhancing employment support for individuals through certified peer specialists. Certified peer specialists work primarily in Medicaid-funded peer support services. More than 2,500 persons have met the training requirement in Pennsylvania, and another 1,000 have been trained as supervisors. As of February 2013, Pennsylvania had 93 approved and licensed peer support service programs.

Other Innovative Programs

Mental Health Matters

Mental Health Matters is a long-term campaign by DPW to help eliminate mental health stigma and prejudices that prevent people from reaching out for help. Among the efforts included in this campaign is support to enable counties to sponsor mental health first aid training. This would include training non-professionals such as librarians and soup kitchen volunteers to help to quickly identify and assist a person with a mental disorder.

The Service Members, Veterans, Family Members Military Project is a collaborative public-private effort to reduce suicide among veterans. Another effort assists families in the role of first responder to mental health concerns within their families.⁹⁰

Compeer

Compeer matches volunteers in one-to-one friendships with adults who have been referred by mental health professionals. Volunteers receive training. There are 9 active Compeer affiliates throughout Pennsylvania.⁹¹

⁸⁹ Substance Abuse and Mental Health Services Administration. "MedTEAM: Building Your Program," HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 2010.

⁹⁰ *Supra*, note 70 at pages 16-17.

⁹¹ *Ibid.*, at page 30.

Telepsychiatry

Telepsychiatry uses electronic communication to provide or support clinical psychiatric care at a distance and is particularly useful in rural areas. Services include evaluating patients in crisis and in need of services, when on-site services are not available due to distance, location, time of day, or availability of resources. Services are provided by psychiatrists and licensed psychologists using real-time two-way interactive audio-video transmission. Telepsychiatry programs serve 41 counties.⁹²

Training

Behavioral health training is available to community service providers, consumers, family members, and other stakeholders through three training institutes. Drexel University Behavioral Health Education, Penn State Education and Health Services, and the Western Psychiatric Institute and Clinic provide training an ever-expanding list of topics relating to mental illness.⁹³

OMHSAS provides training to emergency service providers to address the psychosocial consequences of disasters and emergencies. Training includes psychological first aid, disaster crisis outreach and referral and critical incident stress management for first responders. Other groups of individuals, such as leaders of faith-based communities, leaders of non-English speaking communities, consumers, and mental health and drug and alcohol treatment staff may also receive this training through the counties.⁹⁴

⁹² *Ibid.*, at pages 54-55.

⁹³ *Ibid.*, at pages 57-58.

⁹⁴ *Ibid.*, at pages 60-61.

MENTAL HEALTH SERVICES IN THE CRIMINAL JUSTICE SYSTEM

A person with mental illness who runs afoul of the law may receive treatment in several ways, depending upon where they are in the criminal justice process. Treatment of mentally ill state prisoners is under the jurisdiction of the Department of Corrections (DOC); treatment of persons involved in county-based judicial/correctional systems is usually under the jurisdiction of the Department of Public Welfare (DPW) and the county mental health/intellectual disability programs.

Pennsylvania Department of Corrections

The DOC operates 26 facilities, housing approximately 50,000 prisoners. As of December 31, 2013, 5.6 percent of the DOC population was diagnosed with a serious mental illness. DOC believes that undercounting may be occurring and estimates that the number may be closer to 10 percent. The current definition of serious mental illness used by DOC is being reviewed and diagnoses of bipolar disorder, mood disorder, and depression “not otherwise specified (NOS)” are being reevaluated to determine if persons with those diagnoses should also be included in the counts of persons with serious mental illness. Overall, DOC estimates that 19.6 percent of the inmate population is receiving some form of psychiatric services.⁹⁵ DOC offers a spectrum of mental health services that are available to every inmate in the prison system, which include the following:

- Screening for mental health problems on intake.
- Outpatient services for the detection, diagnosis and treatment of mental illness.
- Crisis intervention and management of acute psychiatric episodes.
- Stabilization of persons with mental illness and prevention of psychiatric deterioration in the correctional setting.
- Prevention treatment.
- Referral and admission to a licensed mental health unit or facility.
- Facilities for an inmate whose psychiatric needs exceed the treatment capability of the facility.

⁹⁵ *Supra*, note 13.

Each facility is required to have psychiatric services and staff through contracted services, and every state correctional institution (SCI) provides outpatient psychiatric services. Short-term inpatient mental health units are available for voluntary admissions and involuntary emergency commitments under the Mental Health Procedures Act and are located at the SCIs at Graterford (18 beds), Muncy (12 beds) and Rockview (15 beds). Longer term (more than 90 day) involuntary commitments are placed at SCI Waymart, which has a capacity of 90. Community based residential and treatment services are based in Philadelphia and Allegheny Counties to help facilitate an inmate's transition back to community life.⁹⁶

Within the various correctional institutions are a number of special needs housing units, including:

- Restricted Housing Units (RHU), which are segregated units used for disciplinary purposes or to protect the security of the prison or the individual prisoner.
- Intermediate Care Unit, which is located at SCI Waymart and is a living unit that accepts inmates who have a history of serious mental illness, psychiatric hospitalizations, and Secure Special Needs Units (SSNU) placements.
- Special Assessment Unit, which provides additional diagnostic and assessment services for an inmate with mental illness who displays serious behavioral problems.
- Special Observation Unit, which provides for observation and assessment of newly committed inmates who are experiencing stress and are suspected of having mental health problems.⁹⁷

Until the winter of 2013-2014, SSNUs housed inmates with a serious mental illness who have a history of disciplinary infractions. These units have been replaced Secure Residential Treatment Units (SRTU). Inmates in SRTUs have a serious mental illness but do not meet involuntary commitment criteria. Inmates generally are permitted out of their cells for 20 hours per week – 10 hours of structured activities and 10 hours of unstructured activities. As of February 2014, approximately 140 inmates could be served in these units in the following SCIs: Pittsburgh (50), Smithfield (20), Rockview (25), Frackville (8), Retreat (8), Muncy (10-12), and Graterford (15-18). SCI Rockview is currently undergoing an expansion and is anticipated to be able to serve 60 inmates upon completion. SCI Muncy is also expanding, but the anticipated additional bed space is not known at this writing.⁹⁸

⁹⁶ Information in this section derived from “Access to Mental Health Care,” Policy Statement No. 13.8.1, Department of Corrections, Commonwealth of Pennsylvania, effective June 14, 2004.

⁹⁷ *Ibid.*

⁹⁸ *Supra*, note 16.

Forensic Treatment Center at Waymart State Correctional Institution

SCI Waymart has a total operational bed capacity of 1,522 inmates, including the 81 beds available in its Forensic Treatment Center. It is also minimum-security men's correctional institution. The Forensic Treatment Center houses mentally disabled male inmates who require inpatient psychiatric care and treatment.⁹⁹

Bureau of Community Corrections

This bureau is responsible for residential facilities located in various Pennsylvania communities. These facilities, also known as halfway houses, provide a transitional process by allowing residents monitored contact with employment and educational opportunities. The facilities house state intermediate punishment inmates and offenders who have been granted parole by the Pennsylvania Board of Probation and Parole. The department also contracts with private vendors to provide specialized treatment and supervision service, many in the area of substance abuse programming.¹⁰⁰ It was estimated that approximately 3,500 state offenders (inmates re-entering the community from SCIs) would be served in the community corrections centers in 2014, with an additional 700 housed in county jails. Approximately 85-90 percent of those persons are anticipated to be parolees, with the remainder being state intermediate punishment inmates.¹⁰¹

The Pennsylvania Department of Public Welfare

DPW operates two regional forensic psychiatric units at Norristown State Hospital and Torrance State Hospital. They provide inpatient evaluation and treatment for persons who have been found not guilty by reason of insanity and persons who are involved with the county-based judicial/correction systems. A person referred for admission must be under criminal detention by this system. Persons eligible include persons who have been adjudicated incompetent to stand trial and (1) are subject to reexamination of competency; or (2) for whom involuntary treatment in an inpatient facility is reasonably certain to provide the individual with competency to proceed to trial. For those persons committed for psychiatric treatment, the anticipated outcome is that with stabilization of symptoms, the individual will return to the judicial system. For those individuals referred for court

⁹⁹ Information about Waymart SCI derived from "Performance Audit, State Correctional Institution at Waymart, Department of The Auditor General, Commonwealth of Pennsylvania, December 2011 and "Monthly Population Report," Department of Corrections, Commonwealth of Pennsylvania, December 31, 2013, http://www.portal.state.pa.us/portal/server.pt/community/research___statistics/10669/monthly_population_reports/1069959.

¹⁰⁰ Bureau of Community Corrections, Department of Corrections, Commonwealth of Pennsylvania, <http://www.portal.state.pa.us/portal/server.pt?open=512&objID=14823&mode=2>.

¹⁰¹ Governor's Executive Budget, Commonwealth of Pennsylvania, 2014-2015, at page E13.7. State Intermediate Punishment is a program in which inmates with alcohol and other substance abuse problems participate in treatment programs while in prison, followed by treatment in the community. *Ibid*, at page E13.6-7.

ordered evaluations, the outcome is their return to the judicial system with a comprehensive psychiatric evaluation forwarded to the court of jurisdiction. Persons serving sentences in SCIs may not be committed for treatment to the forensic unit of a state mental hospital. The only exception to this rule is the three female beds available at Torrance State Hospital for use by individuals incarcerated at SCI Muncy.¹⁰²

Regional Forensic Unit at Norristown State Hospital

Norristown's regional forensic unit has a bed capacity of 136 and serves men and women from the following 19 counties: Berks, Bucks, Carbon, Chester, Delaware, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Monroe, Montgomery, Northampton, Philadelphia, Pike, Schuylkill, Susquehanna, Wayne and Wyoming. Services are also provided to women from SCI Muncy.

Regional Forensic Psychiatric Center at Torrance State Hospital

Torrance's regional forensic center provides treatment and evaluation services to men and women from 48 counties: Adams, Allegheny, Armstrong, Beaver, Bedford, Blair, Bradford, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lawrence, Lycoming, McKean, Mercer, Mifflin, Montour, Northumberland, Perry, Potter, Snyder, Somerset, Sullivan, Tioga, Union, Venango, Warren, Washington, Westmoreland, and York. It has a bed capacity of 97.

In addition, Torrance is the home of DPW's Sexual Responsibility and Treatment Program (SRTP). Usually referred to as the Act 21 program after its authorizing legislation,¹⁰³ program provides mental health and sex-offense specific treatment for children who were adjudicated delinquent because of certain sex-related crimes. While these individuals remain in juvenile treatment programs, they may still pose a significant risk to sexually re-offend after reaching the age of 21, an age when the oversight of the juvenile justice system ends. Act 21 mandates that a person who is committed to an adolescent treatment facility for sex crimes who may still be at risk to re-offend and is about to reach the age of twenty, be identified ninety days prior to their birth date. Upon identification, the Pennsylvania Sexual Offenders Assessment Board (SOAB) is required to conduct an evaluation to determine if a person has "serious difficulty in controlling sexually violent behavior." The SOAB will also determine if the person meets the criteria for "dangerousness" as defined by Act 21. If so, a petition for a mental health hearing is performed affording the individual due process. If it is determined by the court that a civil commitment is warranted, the now 20-year old will be committed to the SRTP. A yearly commitment review occurs for each resident at which time a decision is made to continue treatment or begin community re-integration. This program has a maximum capacity of 37.

¹⁰² "Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers," Office of Mental Health and Substance Abuse Services Policy, Department of Public Welfare, Commonwealth of Pennsylvania. No. SMH-P-12-5. April 11, 2012.

¹⁰³ Act of August 14, 2003 (P.L.97, No.21).

County Correctional Institutions

Persons with mental illness involved in the criminal justice system may be admitted to civil wards of state mental hospitals under all of the following circumstances:

- The person has been charged with, convicted or found not guilty by reason of insanity of a minor, non-violent offense.
- The person is not sentenced to the jurisdiction of the DOC.
- The person does not require the security level of a forensic unit.¹⁰⁴

Each county correctional institution is required to maintain a local written policy complying with minimum standards in policies, procedures and facilities, and is subject to annual inspections by the DOC to ensure compliance with those standards. With respect to treatment services, each policy must designate that the delivery of treatment services are supervised by a treatment professional who is employed by the prison, who is under contract with the prison, or who serves as a volunteer. Each inmate must receive a treatment intake screening that must include a determination of the inmate's current mental and emotional stability. The written policy must also identify the procedures for evaluating whether an inmate is mentally ill and whether proceedings under the MHPA should be initiated.¹⁰⁵

Persons incarcerated in county jails and prisons may also receive mental health services through the local community mental health/intellectual disability programs available in that county.¹⁰⁶

Pennsylvania Commission on Crime and Delinquency

Part of the mission of the Pennsylvania Commission on Crime and Delinquency is to enhance the quality and coordination of criminal and juvenile justice systems in Pennsylvania. Its Office of Criminal Justice System Improvements (OCJSI) advances its role in justice planning by coordinating with all levels of criminal justice agencies in identifying their issues, developing statewide policies and programs, and implementing innovative justice improvement solutions that enhance public safety.

¹⁰⁴ *Supra*, note 29.

¹⁰⁵ 37 Pa. Code § 95.243(1), (4), (5) and (7).

¹⁰⁶ Office of County Inspection and Services, Department of Corrections, Commonwealth of Pennsylvania. http://www.cor.state.pa.us/portal/server.pt/community/county_prisons/20863.

Mental Health and Justice Advisory Committee

Through its Mental Health and Justice Advisory Committee, PCCD assists communities in dealing with mental health issues in the criminal justice system. OCJSI and DPW's OMHSAS established the Mental Health and Justice Advisory Committee in the summer of 2009.¹⁰⁷

This advisory committee provides guidance and structure to ensure that Pennsylvania's criminal justice/mental health activities are coordinated statewide and that counties receive the guidance and support necessary to implement effective responses. In partnership with DPW/OMHSAS, the advisory committee includes representatives from state agencies, county leadership, the courts, district attorneys, public defenders, consumers and families, and other criminal justice and mental health advocates and practitioners from across the Commonwealth. The Committee is chaired by the Honorable John Zottola of Allegheny County.¹⁰⁸

Pennsylvania Mental Health and Justice Center of Excellence

In February 2010, OCJSI and OMHSAS jointly announced the creation of The Strategic Plan and also called for the creation of a Center of Excellence for the development and improvement of programs serving adults with mental illness involved in the criminal justice system. The Center of Excellence was promptly organized, and is co-directed by the Drexel University Department of Psychology and the University of Pittsburgh Medical Center. The Center promotes the proliferation of evidence-based and promising practices by providing technical assistance in support of the start-up, operation, and sustainability of jail diversion and reentry programs; and it acts as a clearinghouse for information and resources related to criminal justice, mental health, and substance abuse. The Center provides training and technical assistance to communities and supports evidence-based practices that reduce involvement of persons with mental illness/co-occurring disorders in the criminal justice system. The Center provides training to counties on the sequential intercept model and cross-systems mapping via a workshop that examines the process in counties of ways to "intercept" justice-involved persons with mental illness.¹⁰⁹ Twenty-seven counties have successfully completed cross-mapping workshops, and another 6 are in progress.¹¹⁰

¹⁰⁷ PCCD is authorized to appoint advisory committees under §3(18) of the Pennsylvania Commission on Crime and Delinquency Law, act of November 22, 1978 (P.L.1166, No.274).

¹⁰⁸ "Mental Health and Justice Advisory Committee,"

<http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5385&&SortOrder=100&level=3&parentid=5326&css=L3&mode=2>.

¹⁰⁹ *Ibid.*

¹¹⁰ *Supra*, note 56, at page 31.

Justice Reinvestment Working Group

The Justice Reinvestment Working Group, a bipartisan, inter-branch organization established under PCCD in 2011, includes state cabinet secretaries, Republican and Democratic lawmakers, court officials, and other stakeholders in the criminal justice system. Extensive data were compiled from various agencies and provided to the Council of State Governments (CSG) Justice Center. With help from the Pew Center on the States, CSG Justice Center staff will conduct a comprehensive analysis of these data and present findings to the working group. Based on comments and advice from members, and findings and input from criminal justice system stakeholders, a comprehensive set of policy options will be developed that both increase public safety and reduce corrections spending.¹¹¹

Criminal Justice Advisory Boards

PCCD has been responsible for implementing County Criminal Justice Advisory Boards (CJABs). PCCD and OCJSI assist CJABs in every phase of development including providing start-up grants, strategic planning assistance and project implementation support. CJABs address criminal justice issues from a systemic and policy level perspective. CJABs study best practices in the administration and delivery of criminal justice and recommend ways in which public agencies can improve the effectiveness and efficiency of the criminal justice system within a county. A CJAB's membership is comprised of individuals with the authority and credibility to effect the delivery of criminal justice/public safety and service on the county and local levels. Membership should include representatives of the county governing body, judiciary, district attorney or designee, public defender, county law enforcement, sheriff or designee, adult probation, juvenile probation, adult corrections, juvenile detention, local victims' organizations and local public and/or non-profit human assistance services organizations. Currently, 65 counties have established CJABs. CJABs are frequently designated as the primary point of contact with the commonwealth and the federal government for criminal justice matters.¹¹²

Pennsylvania Board of Probation and Parole

PBPP is responsible for establishing statewide standards applicable to all counties with regard to persons on probation or parole, including probation and parole personnel and program standards, training for county adult probation and parole personnel, and collecting, compiling, and publishing county probation and parole statistical information. The Advisory Committee on Probation assists the PBPP in formulating and reviewing standards for probation personnel and program services for the counties.

¹¹¹ "Justice Reinvestment in Pennsylvania: Overview," Justice Center, the Council of State Governments, January 2012,

http://www.pccd.state.pa.us/portal/server.pt/community/justice_reinvestment_initiative/20702.

¹¹² "Criminal Justice Advisory Boards (CJABs)," Pennsylvania Commission on Crime and Delinquency, <http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5280&&PageID=493307&level=3&css=L3&mode=2>. CJABs are created under the authority of the PCCD law, Act of November 22, 1978 (P.L.274, No.1166), §3(18), 71 P.S. § 1190.23(18).

PBPP has the responsibility to parole, recommit for violations of parole, and to discharge from parole offenders sentenced to two years or more and offenders requested by the court for special probation. PBPP's goal to protect the safety of the public is accomplished through effective parole decisions and proper supervision and management of offenders who are returning to their communities.¹¹³ Planning for prisoners' successful reentry into the community begins at the start of the person's incarceration, and is the focus of PBPP's community reentry division. Successful reentry can increase public safety, improve the health of the community, sustain families, improve the welfare of children, prevent recidivism, and lower costly criminal justice expenses.¹¹⁴

¹¹³ "Understanding Pennsylvania Parole," Pennsylvania Board of Probation and Parole, http://www.pbpp.state.pa.us/portal/server.pt/community/understanding_pennsylvania_parole/5356.

¹¹⁴ "Community Reentry," Pennsylvania Board of Probation and Parole, http://www.pbpp.state.pa.us/portal/server.pt/community/community_reentry/5357.

FUNDING PENNSYLVANIA'S MENTAL HEALTH SYSTEM

Pennsylvania's mental health system is financed by a combination of federal, state and county dollars designated for mental health services. Additional funds include home- and community-based waivers for elderly persons and persons with physical disabilities who also have mental illnesses, consolidated waivers for persons with intellectual disabilities and mental illness, Department of Aging programs and services, publicly-funded housing programs, veterans' programs, Social Security Disability, Supplemental Security Income, Medicare, Medical Assistance, educational benefits, and veterans' benefits.¹¹⁵ An individual receiving services under the public mental health system is personally liable for the costs of any services received until the individual has exhausted his eligibility and receipt of benefits under all other private, public, local, state or federal programs.¹¹⁶ In essence, the Commonwealth is the payor of last resort.

State Mental Health Services Expenditures

In 2010, Pennsylvania was ranked fourth nationally for per capita mental health services expenditures. Cuts in funding in 2011 and 2012 by the District of Columbia and the State of Alaska have reordered these rankings, and Pennsylvania currently ranks second nationally for per capita mental health expenditures, after Maine. While Pennsylvania's ranking has improved, it is not due to increasing expenditures in Pennsylvania, but rather by the draconian cuts experienced in other states. The loss of federal stimulus money in 2011 and the general state of the economy are frequently cited as causes for the overall nationwide decline in state mental health spending. This nationwide decline has caused great concern to the people who are responsible for providing services to those with mental illnesses:

[I]f continued state and federal funding cuts are the norm over the next few years, several programs that SBHAs [State Behavioral Health Authorities] manage will certainly be significantly curtailed or eliminated altogether to the detriment of our most vulnerable and sickest individuals, as well as for their families, and those individuals who have less severe conditions, but who suffer from their illnesses nonetheless. Many people with complex clinical and social needs will have to fend for themselves if services disappear and their conditions go untreated due to funding cuts. . . . SBHAs recognize that untreated behavioral health issues will cause unnecessary

¹¹⁵ *Supra*, note 15, at page 4.

¹¹⁶ Act of October 20, 1966, Sp. Sess. 3 (P.L.96, No.6) known as the Mental Health and Intellectual Disability Act of 1966, §§ 501-508; 50 Pa. Stat. Ann. §§4501-4508.

disability, unemployment, substance abuse, family disruption, homelessness and inappropriate incarceration.¹¹⁷

The table below shows Pennsylvania's ranking in 2010 as one of the 10 states with the highest expenditures per capita. The last column reflects the changes in state mental health budgets during the three-year period 2009-2012.

Table 3
Per Capita Mental Health Services Expenditures
By Selected States and the District of Columbia, 2009-2012

State	Total Expenditures	Per Capita Expenditures In 2010	Percentage Change in State Mental Health Budget, 2009-2012
D.C.	\$217,069,846	\$360.57	-23.9%
Maine	459,680,997	346.92	+15.4%
Alaska	214,200,700	310.01	-32.6%
Pennsylvania	3,568,718,516	280.78	-0.8%
New York	4,965,000,000	256.31	-5.4%
Vermont	150,000,000	239.84	+1.0%
Arizona	1,414,300,000	221.27	+5.6%
New Jersey	1,758,813,000	200.09	+4.7%
Connecticut	675,500,000	189.34	+5.8%
Montana	171,381,791	173.59	-5.8%

Source: Compiled by JSGC staff from Governing, "Mental Health Spending: State Agency Totals," <http://www.governing.com/gov-data/health/mental-health-spending-by-statee.html>, Kaiser Family Foundation, "State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures," <http://kff.org/other/state-indicator/smha-expenditures-per-capita/>, and National Alliance on Mental Illness, "State Mental Health Cuts: The Continuing Crisis," Appendix III: State Mental Health Budgets FY2009-FY2012, November 2011.

State Funding for Community Mental Health /Intellectual Disability Programs

Grants to counties by the Department of Public Welfare are generally allocated to provide services as follows:

- For low-income adults and older individuals eligible for services under the Human Services Development Fund Act.¹¹⁸
- For mental health and intellectual disability services under The Mental Health and Intellectual Disability Act of 1966.¹¹⁹
- For behavioral health services.

¹¹⁷ *Supra*, note 66, at page v.

¹¹⁸ Act of October 5, 1994 (P.L.531, No.78), 62 P.S.A. § 3101 *et seq.*

¹¹⁹ *Supra*, note 32.

- For drug and alcohol services under section 2334 of The Administrative Code of 1929.¹²⁰
- For the provision of services to the homeless.
- For county child welfare agencies to provide services to dependent and delinquent children.

Although Pennsylvania ranks as one of the highest spending states in the country, to quote Erasmus, “In the land of the blind, the one-eyed man is king.” The county mental health and intellectual disability programs reported that they have experienced several years of budget challenges, including a 10 percent cut in the fiscal year 2012-2013 Commonwealth budget.

In response to a survey conducted by the County Commissioners Association of Pennsylvania, 89 percent of responding counties reported reduced program and service capacity at the local level, and 63 percent of the responding counties eliminated one or more programs or services as of December 2012.¹²¹ The survey revealed that 10 counties had reduced or eliminated some type of employment, education or training. Housing or residential services were cut or reduced in 17 counties. Social rehabilitation services (such as drop-in centers and other forms of peer support) were cut in 20 counties. Numerous counties reported negative budget impacts on their psychiatric rehabilitation services, while a vast majority had to reduce funding for treatment and direct services, or limit the frequency or duration of those services. Additionally, 95 percent of the responding counties reported cuts through administrative changes, and 34 percent had to lay off employees.¹²²

For example, Allegheny County reported reductions in the number of consumers served between July 2011 and July 2012 in the following programs: intensive case management, outpatient, psychiatric inpatient, community employment, facility-based vocational rehabilitation, social rehabilitation, family support services, community residential services, family-based mental health, administrative management, emergency services, housing support, community treatment teams, and psychiatric rehabilitation. Mental health crisis intervention was the only program reported to have experienced growth.¹²³

¹²⁰ Act of April 9, 1929 (P.L.177, No.175), 71 P.S.A. § 611.14.

¹²¹ *Supra*, note 26.

¹²² *Ibid.*

¹²³ “2012-2013 Budget Cut Impacts County Snapshots,” Pennsylvania Association of County Administrators of Mental Health and Developmental Services, accessed at http://www.pmhca.org/advocacy/Budget13_14.html.

Human Services Block Grant Pilot Program

In 2012, amendments were made to the Public Welfare Code¹²⁴ to establish a human services block grant program for counties. State funds were allocated according to each county's proportional share of the aggregate amount of those State funds for fiscal year 2011-2012. Traditionally, DPW allocates specific amounts to be expended in each area identified above to the individual counties. Over a five year period, the counties are given increasing amounts of discretion as to how these funds may be expended for any particular category of county-based human services. Counties are prohibited from eliminating community-based mental health services, intellectual disability services, child welfare services, drug and alcohol treatment and prevention services, homeless assistance services, and behavioral health services, but by fiscal year 2016-2017, they will be able to internally allocate funds to those programs that, in their discretion, best meet local needs. Twenty counties¹²⁵ participated in the block grant program in 2013, and an additional 10 new counties¹²⁶ will be participating in 2014.

This program has been lauded for the flexibility it allows each county in addressing the human services needs unique to that county.

During the first year of implementation, counties have reported great success in their ability to reduce or eliminate waiting lists for key services, and reduce costs for administration, which allows more dollars to be dedicated to direct services. Counties also continue to report better integration between program areas, making it easier for clients and families with multiple needs to obtain seamless services.¹²⁷

Support for the human services block grant program has not been unanimous. Upon its enactment, a preliminary injunction was filed¹²⁸ to halt implementation of the grant program as an unconstitutional delegation of legislative power.¹²⁹ Although the lawsuit ultimately failed, in announcing its joinder in the lawsuit, the Pennsylvania Community Providers Association expressed concern that the discretion afforded counties "will favor some groups and harm others as counties shift money from one service area to another."¹³⁰

¹²⁴ Act of June 13, 1967 (P.L.31, No.21), as amended by the act of June 30, 2012 (P.L.668, No.80), Article XIV-B, §1401-B et seq., 62 P.S.A. § 1401-B et seq.

¹²⁵ Allegheny, Beaver, Berks, Bucks, Butler, Centre, Chester, Crawford, Dauphin, Delaware, Erie, Franklin, Fulton, Greene, Lancaster, Lehigh, Luzerne, Tioga, Venango, and Wayne Counties.

¹²⁶ Blair, Cambria, Lackawanna, McKean, Montgomery, Northampton, Potter, Schuylkill, Washington, and Westmoreland Counties.

¹²⁷ "Counties Welcome Addition of Ten New Counties to the State's Human Services Block Grant," Press Release, County Commissioners Association of Pennsylvania, October 11, 2013, www.pacounties.org.

¹²⁸ The petition was filed by three consumers and the following consumer and provider organizations: the Pennsylvania Mental Health Consumers' Association, Mental Health Association in Pennsylvania, Mental Health Association of Southeastern Pennsylvania, The Philadelphia Alliance, Drug and Alcohol Service Providers Association of Pennsylvania, the Pennsylvania Community Providers Association, and Success Against All Odds.

¹²⁹ *Washington v. Department of Public Welfare*, 76 A.3d 536 (Pa. 2013).

¹³⁰ "PCPA Joins Coalition, Lawsuit to Stop Human Services Block Grant," October 1, 2012, http://www.paproviders.org/Pages/PCPA_News_Archive/HSBG_Lawsuit_100212.shtml.

Recently, the Rehabilitation and Community Providers Association urged legislative support for removing the Community Hospital Integration Projects Program and the Behavioral Health Services Initiative money from the Human Services Block Grant.

With the closure of state institutions, and through funding from CHIPP and the Southeast Integrated Projects Program, promises were made to individuals and to communities that the [C]ommonwealth would provide and maintain community mental health services and supports so that individuals would not be “dumped” into the streets, jails, or emergency rooms in hospitals. Keeping CHIPP dollars in the Human Services Block Grant where they can be used in other programs results in Pennsylvania renegeing on these promises and shifting the burden back to local communities for care that is a state responsibility.¹³¹

Community Mental Health Services Block Grants

A block grant is a noncompetitive, formula grant mandated by the U.S. Congress. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services is responsible for two block grant programs: the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (MHBG). Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Block grant funds may be used for treatment and support services, and for primary prevention.

Pennsylvania anticipates receiving \$14,559,000 in MHBG funds in 2014, of which \$14,286,000 would be allocated to county programs to provide community-based mental health services. Projected block grant allocations to the Commonwealth’s counties for FY 2013-2014 varied considerably. Criteria for allocations include historical prevalence of serious mental illness in a geographic area, percentage of residents living in poverty, epidemiologic statistics and other data collected.¹³²

The table below shows the county programs in order of estimated per capita allotments for adults with serious mental illness, from largest to smallest. These calculations are based on the assumption that all the grant money would be allocated to persons with serious mental illness (SMI). In reality, this is most likely not the case, but these estimates show the maximum amount of these grants that could possibly be allocated to persons with SMI.

¹³¹ “FY 2014/2015 Behavioral Health Budget Priorities,” January 17, 2014, http://www.paproviders.org/Pages/Budget_Archive/14-15_BH_Budget_Priorities.pdf.

¹³² “Community Mental Health Service Block Grant – Fiscal Year 2014-2015,” at page 61, <http://www.dpw.state.pa.us/provider/mentalhealth/>.

Table 4
Federal Community Mental Health Services Block Grant
By Selected County, 2013-2014

County Program	Grant Amount ¹³³	Total Pop. ¹³⁴	Pop. Rank	Est. Pop. with SMI ¹³⁵	Per Capita Grant for Pop. with SMI
Lawrence	\$597,660	89,871	37	3,685	\$35.75
Westmoreland	453,741	363,233	9	14,893	30.47
Tioga	48,440	42,595	44	1,746	27.74
Cambria	634,283	141,584	28	5,805	24.09
Greene	128,264	38,085	46	1,561	18.11
Lackawanna/Susquehanna	701,793	214,477	18	8,794	17.59
Clearfield/Jefferson	410,582	125,948	33	5,164	17.53
Potter	55,099	17,577	48	720	16.86
Washington	564,310	208,716	19	8,557	14.54
Wayne	132,115	51,955	41	2,130	13.67
Clarion	77,680	39,646	45	1,625	10.53
Cumberland/Perry	487,380	284,315	15	11,657	9.22
Dauphin	453,585	269,665	17	11,056	9.04
Venango	89,306	54,272	40	2,225	8.85
Fayette	204,868	135,660	29	5,562	8.12
Philadelphia	2,203,831	1,547,607	1	63,452	7.66
Cameron/Elk	51,880	36,489	47	1,496	7.65
Bedford/Somerset	174,754	126,281	32	5,588	7.44
Bradford/Sullivan	92,161	69,253	39	2,839	7.15
McKean	58,235	43,127	43	1,768	6.87
Erie	337,459	280,646	16	11,506	6.46
Mercer	138,705	115,655	35	4,742	6.45
Beaver	194,379	170,245	21	6,980	6.14
Northumberland	105,063	94,428	36	3,872	5.98
Schuylkill	163,405	147,063	27	6,030	5.97
Allegheny	1,342,083	1,229,338	2	50,403	5.87
Butler	193,295	184,970	20	7,584	5.62
Armstrong/Indiana	151,974	156,627	25	6,422	5.22
Blair	117,288	127,121	31	5,212	4.96
Lycoming/Clinton	139,481	156,685	24	6,424	4.79
Columbia/Montour/Snyder/Union	149,678	169,867	22	6,965	4.74
Forest/Warren	40,837	50,244	42	2,060	4.37
Luzerne/Wyoming	281,771	349,152	12	14,315	4.34
Huntingdon/Mifflin/Juniata	94,322	122,620	34	5,027	4.14
Crawford	64,925	87,598	38	3,592	3.98
Centre	104,253	155,171	26	6,362	3.61
Berks	262,337	413,491	10	16,953	3.41
Delaware	350,196	561,098	5	23,005	3.36
Lebanon	84,080	135,251	30	5,545	3.34
Franklin/Fulton	94,705	166,047	23	6,808	3.07
York/Adams	289,143	539,328	6	22,112	2.88
Lancaster	278,587	526,823	7	21,600	2.84
Montgomery	390,979	808,460	3	33,147	2.60
Carbon/Monroe/Pike	136,604	290,703	14	11,919	2.53
Lehigh	163,558	355,245	11	14,565	2.48
Northampton	135,673	299,267	13	12,270	2.44
Chester	215,432	506,575	8	20,770	2.29
Bucks	258,581	627,053	4	25,709	2.22

AVG = \$8.65

¹³³ *Ibid.*, at pages 61-63.

¹³⁴ Population figures from U.S. Census Bureau estimates for 2012, <http://quickfacts.census.gov/qfd/states/42000.html>.

¹³⁵ *Ibid.*, 4.1% of the populace is considered to have serious mental illness.

Community Hospital Integration Projects Program (CHIPP)

The CHIPP program, administered by the Office of Mental Health and Substance Abuse Services (OMHSAS) and funded by DPW, provides funding to counties to provide community services to individuals who are discharged from state hospitals as part of hospital closure plans. In determining which patients should be discharged from the state hospital and supported by CHIPP, priority is given to those persons who have been hospitalized for over two years and have been unable to be successfully supported in the community. All CHIPP-funded programs must comply with the following:

- Each person must have a community support plan and individualized crisis plan prepared as their plan of discharge.
- Each person should be assigned one of the following: an intensive case manager, a blended case manager, assertive community treatment team, or community treatment team.
- All counties receiving CHIPP funds must establish and maintain a consumer/family satisfaction team.
- Counties are encouraged to help build up existing consumer directed services, such as drop-in centers, peer mentors, peer specialists, warm lines and other consumer-run services.
- Counties should promote and develop integrated supportive housing.
- No person discharged from a state mental hospital may be referred to a personal care home with more than 16 beds.
- If an individual supported by CHIPP funds is arrested and incarcerated for less than six months, the county must ensure that needed services and supports are being provided in the jail.
- If a person is discharged to another county other than the county in which the state mental hospital is located, there must be an agreement between the two counties as to financial and programmatic responsibilities.
- Funds may not be used to develop or provide services to children and adolescents, to fund placement in a nursing facility or community private inpatient psychiatric hospital.
- Nursing home placements should be avoided.¹³⁶

¹³⁶ Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, "Community Hospital Integration Projects Program (CHIPP) Guidelines," July 2013.

In its budget request for fiscal year 2014-2015, DPW has requested \$4,725,000 to provide home and community-based services for 90 individuals currently residing in state hospitals.¹³⁷ In fiscal year 2012-2013, total CHIP/SIPP¹³⁸ funding was \$244.2 million.

Justice Reinvestment Initiative

The Criminal Justice Reform Act¹³⁹ was part of a package of criminal justice reforms that were adopted in 2012. The intention was to reduce the number of persons in state correctional institutions. Under a second piece of legislation enacted in October 2012¹⁴⁰ a grant program was established within the Pennsylvania Commission on Crime and Delinquency. Money saved from the decrease in prisoners in the state prisons would be reinvested at the county level to prevent persons from being incarcerated in the first place. It was anticipated that this funding mechanism would produce savings of \$9.5 million in 2013, of which \$8.5 million would be earmarked for local programs. Instead, due to low performance of a number of initiatives, only \$43,000 was added to the Justice Reinvestment Fund.¹⁴¹ While the 2013 results are discouraging, 2013 was the first full year the initiatives were in place, and it is hoped that as the initiatives achieve a firmer footing in the county courts, future years will see greater reinvestments.

Melville 811 Resources

In February 2013, Pennsylvania was awarded \$5.7 million in resources under the Frank Melville Supportive Housing Investment Act of 2010.¹⁴² These funds are intended to be used to assist extremely low-income individuals with disabilities, including those persons leaving state institutions, with rental assistance.¹⁴³

Insurance Parity

In an effort to increase the availability of private dollars to help pay for mental health treatment, there has been a movement toward requiring insurance companies that offer mental health benefits to make those benefits equivalent to those provided for other, more physical ailments.

¹³⁷ Governor's Executive Budget, Commonwealth of Pennsylvania, 2014-2015, at page E37.25.

¹³⁸ Southeast Integration Project Programs was developed for the closure of Philadelphia State Hospital.

¹³⁹ Act of July 5, 2012 (No. 122, P.L.1050), amending Titles 18, 42 and 61 of the Pennsylvania Consolidated Statutes.

¹⁴⁰ Amendments to the Pennsylvania Commission and Crime and Delinquency's governing law enacted as the Act of October 25, 2012 (No.196, P.L.1607), generally, 71 P.S.A. § 1190.21 *et seq.*

¹⁴¹ Pennsylvania Board of Probation and Parole, Commonwealth of Pennsylvania, "Justice Reinvestment Initiative: Status Report – June 30, 2012 to January 31, 2014," and Donald Gilliland, "Reform Continues to Elude Corbett," *The Patriot-News*, Harrisburg, PA, February 25, 2014, at page A1.

¹⁴² Pub. L. 111-374, 42 U.S.C. § 8013.

¹⁴³ *Supra*, note 70.

The federal Mental Health Parity and Addiction Equity Act of 2008¹⁴⁴ (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. The MHPAEA preempts state law only to the extent a state standard or requirement prevents its application.¹⁴⁵

Pennsylvania implemented the MHPAEA by enacting the Health Insurance Coverage Parity and Nondiscrimination Act,¹⁴⁶ but retained its authority to regulate health insurance in the Commonwealth. Specifically, the Insurance Company Law of 1921¹⁴⁷ provides for minimum coverage standards for mental illness for large health insurance plans (defined as plans covering groups of 50 or more employees).

Section 1416 of the Public Welfare Code¹⁴⁸ requires insurers who provide inpatient psychiatric care coverage to reimburse State-owned psychiatric hospitals at the same rate as it does to contracted psychiatric hospital providers. If there is no such rate, the requisite reimbursement would be at the rate that the medical assistance program would pay for such coverage, even if the hospital does not have a provider agreement with the insurer or does not participate in the insurer's network.

In 1996, the U.S. Department of Health and Human Services established the Community Preventive Services Task Force, an independent, uncompensated panel of public health and prevention experts to provide information to decision-makers on programs, services and policies aimed at improving population health. Members are appointed by the Director of the Centers for Disease Control and Prevention (CDC), and the task force receives administrative support from the CDC.¹⁴⁹ The task force completed a study on mental health parity legislation and in January 2014 released its findings and recommendations in favor of parity legislation. The task force found that mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates. The task force also stated that evidence from a concurrent economic review indicated that mental health benefits expansion did not lead to any substantial increase in cost to health insurance plans, measured as a percentage of premiums.¹⁵⁰

¹⁴⁴ Pub. L. 110-343, 122 Stat. 3881 (2008).

¹⁴⁵ 196 Prop. Treas. Reg. Part 54, 75 Federal Register 5452 (February 2, 2010).

¹⁴⁶ Act of May 17, 1921 (P.L.682, No.284) art. VI-B; 40 Pa. Stat. Ann. § 908-11 *et seq.*

¹⁴⁷ *Ibid.*, at § 635.1; 40 Pa. Stat. Ann. § 764g.

¹⁴⁸ *Supra*, note 124, § 1416; 62 Pa. Stat. Ann. § 1416.

¹⁴⁹ The Community Preventive Services Task Force, <http://www.thecommunityguide.org/about/task-force-members.html>.

¹⁵⁰ "Improving Mental Health and Addressing Mental Illness: Mental Health Benefits Legislation," The Community Guide, Community Preventive Services Task Force, January 3, 2014, <http://www.thecommunityguide.org/mentalhealth/RRbenefitslegis.html>.

Medicaid Expansion

The federal Patient Protection and Affordable Care Act¹⁵¹ (PPACA) expands the federal parity requirements to health insurance issued in the individual and small group markets effective January 1, 2014, which is anticipated to make an additional 30 million people subject to the federal parity rules.¹⁵² On February 19, 2014, Pennsylvania Governor Tom Corbett submitted a waiver proposal to the U.S. Department of Health and Human Services that would adopt a unique version of Medicaid expansion for Pennsylvania. With respect to coverage of mental health services by Medical Assistance (Pennsylvania's version of Medicaid), the proposal increases the number of outpatient mental health treatment visits covered per year (both clinic based and mobile services). The proposal includes a requirement that persons receiving medical assistance actively search for employment, but medically frail persons¹⁵³ are exempt from this requirement. Under the proposal, targeted case management will continue to be available for persons with diagnosed serious mental illnesses. Generally, DPW expects the proposed program to comply with federal and state parity and network adequacy requirements for behavioral health services.¹⁵⁴

Medicaid for Inmates

Under current Medicaid/Medical Assistance law, anyone entering a state prison or local jail loses Medicaid eligibility on the theory that state and local governments have historically taken responsibility for inmate health care. In 1997, the U.S. Department of Health and Human Services announced that inmates who leave correctional facilities for treatment in local hospitals can get their bills paid by Medicaid.¹⁵⁵ However, the inmate must otherwise be eligible for Medical Assistance, and in Pennsylvania, most inmates do not fall into the eligibility categories established by the Commonwealth. There are income, resource (in many cases), and other eligibility requirements in order to be eligible for Medical Assistance. These categories are grouped by:

- Individuals who are aged (age 65 and older), blind, and disabled.
- Families with children under age 21.

¹⁵¹ Pub. L. 111-148, 124 Stat. 119 (2010).

¹⁵² "Affordable Care Act Will Expand Mental Health and Substance Use Disorders Benefits and Parity Protections for 62 Million Americans," Kirsten Beronio, Rosa Po, Laura Skopec and Sherry Glied, ASPE Research Brief, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, February 20, 2013, http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm.

¹⁵³ "Medically frail" includes a person with a condition based on a disabling mental disorder, defined as: a psychotic disorder, schizophrenia, a schizoaffective disorder, major depression, a bipolar disorder, a delusional disorder or an anxiety disorder (obsessive compulsive, post-traumatic stress or severe panic).

¹⁵⁴ Department of Public Welfare, Commonwealth of Pennsylvania, "Healthy Pennsylvania 1115 Application," February 19, 2014, <http://www.dpw.state.pa.us/healthypa/>.

¹⁵⁵ Christine Vestal, "Medicaid Expansion Seen Covering Nearly All State Prisoners," *Stateline*, October 18, 2011. http://www.governing.com/templates/gov_print_article?id=132053913.

- Single and married individuals with a temporary disability, age 59 through 64, limited income or special circumstances.
- Individuals under-going drug and alcohol treatment.
- Victims of domestic violence.
- Individuals caring for a child or disabled person.
- Individuals with special Medical Assistance conditions (such as breast or cervical cancer).¹⁵⁶

With Medicaid expansion, it is possible that virtually all state prison inmates could be eligible of coverage of hospital stays, a major cost-cutting opportunity for state corrections agencies.¹⁵⁷

Estate Recovery

Generally, under Pennsylvania law, no repayment of Medical Assistance is required.¹⁵⁸ However, the estates of individuals who received Medical Assistance for nursing facility services, home- and community-based services, or related hospital and prescription drug services who were 55 years of age or older at the time the Medical Assistance was received are liable to repay DPW for the amount of Medical Assistance from the time the individual was 55 years of age and thereafter.¹⁵⁹ Additionally, there is an existing law from 1915 that provides that the spouse, parent, and children of a person in a state-owned mental hospital is liable to pay for the maintenance of the person.¹⁶⁰ It appears this 1915 statute has been superseded in part and is not in active use, in which case it should be repealed.

¹⁵⁶ Department of Public Welfare, Commonwealth of Pennsylvania, “Medical Assistance General Eligibility Requirements,” <http://www.dpw.state.pa.us/foradults/healthcaremedicalassistance/medicalassistancegeneraleligibilityrequirements/> .

¹⁵⁷ *Supra*, note 155.

¹⁵⁸ *Supra*, note 124, § 447, 62 P.S.A. § 447.

¹⁵⁹ *Ibid.*, § 1412, 62 P.S.A. § 1412; 55 Pa. Code § 258.1 et seq.

¹⁶⁰ Act of June 1, 1915 (P.L.661, No.293), 71 P.S.A. § 1781 et seq.

AREAS OF CONCERN: THE MENTAL HEALTH SYSTEM

Pennsylvania's Mental Health Procedures Act (MHPA) governs all inpatient psychiatric treatment, whether voluntary or involuntary as well as involuntary outpatient treatment. The statute has been criticized as too narrowly defining behavior that may result in involuntary commitment. Suggestions have been made to alter various aspects of the commitment criteria, such as the nature of the potential harm to be avoided and the time frame to consider in reviewing behavior that may be the basis for an involuntary commitment. Other suggestions have included adopting additional forms of involuntary commitment such as assisted outpatient commitment.

Current Involuntary Commitment Standards

In order to be involuntarily committed in Pennsylvania, a person must be severely mentally disabled and in need of immediate treatment. Severely mentally disabled is defined as follows:

[A]s a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.¹⁶¹

Clear and Present Danger of Harm to Others

Clear and present danger of harm to another contains three behavior elements that must be met:

- The conduct in question must have occurred in the past 30 days.
- The person must have inflicted or attempted to inflict serious bodily harm on another, or made threats of harm and committed acts in furtherance of the threat to commit harm.
- There is a reasonable probability that the conduct will be repeated.

¹⁶¹ MHPA § 301(a), 50 P.S.A. § 7301(a).

Clear and Present Danger of Harm to Self

Clear and present danger of harm to self can involve self-neglect, suicide or self-mutilation. Within each category, specific criteria must be met.

Suicide

- The conduct in question must have occurred in the past 30 days.
- The person has attempted suicide, made threats to commit suicide and committed acts that are in furtherance of that threat.
- There is a reasonable probability of suicide unless adequate treatment is afforded under the MHPA.

Self-mutilation

- The conduct in question must have occurred in the past 30 days.
- The person has substantially mutilated himself or attempted to mutilate himself substantially, or made threats to commit mutilation and committed acts that are in furtherance of that threat.
- There is a reasonable probability of self-mutilation unless adequate treatment is afforded under the MHPA.

Self-neglect

- The conduct in question must have occurred in the past 30 days.
- The person has acted in such manner as to evidence that he would be unable, without care, supervision, and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety.
- There is a reasonable probability that death, serious injury, or serious physical debilitation would ensue within 30 days unless adequate treatment is afforded under the MHPA.

Problematic Standards

Concerns have been raised regarding several aspects of Pennsylvania's involuntary civil commitment standards, primarily by family members who have found it difficult to obtain an intervention for a family member with mental illness before the family member has reached crisis mode.

Serious bodily harm

The MHPA requires, as part of the danger of harm to others, that a person inflict or attempt to inflict serious bodily harm on another. Serious bodily harm is not defined in the MHPA. There is anecdotal evidence that this term is frequently equated with the Pennsylvania Crimes Code term, “serious bodily injury,” is defined as “bodily injury which creates a substantial risk of death or which causes serious, permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ.”¹⁶² In these instances, behavior that would be considered a simple assault would not meet the definition of danger. While there are not many court decisions interpreting the meaning of “serious bodily harm,” something less than criminal assault appears to be required.¹⁶³

Under Pennsylvania’s definitions, the harm or attempted harm must be directed at a person or oneself. Property damage is not included. Simply being mentally ill is not a justification for the deprivation of personal liberties entailed in an involuntary commitment. However, a mental illness that manifests itself by causing a young man to destroy a room in his home by repeatedly smashing the walls with a hammer because the voices in his head told him to do so can reasonably be interpreted to represent a danger to others.¹⁶⁴ Six other states include substantial property damage.¹⁶⁵

Serious physical debilitation

Current law regarding self-neglect looks to serious physical debilitation occurring the next 30 days as proof of danger to self. The concern with the criteria is its limitation to physical debilitation. “Debilitate” has been defined as “to make weak or infirm.”¹⁶⁶ Suggestions have been made to eliminate the requirement that the debilitation be physical in nature. Further refinements to this concept include limiting the mental debilitation to that resulting from a diagnosed condition and a finding that the individual does not have the capacity to make a rational treatment decision. Fourteen states allow consideration of potential mental deterioration in determining if a person is a danger to self.¹⁶⁷

Predictability

Under the definition of self-neglect, there must be a reasonable probability that the danger to self will ensue in the next 30 days. The statute requires that only conduct occurring in the previous 30 days may be considered as evidence of the potential danger. Most states look to recent behavior by the person to determine dangerousness. Only two

¹⁶² 18 Pa.C.S. § 2301.

¹⁶³ The Pennsylvania Superior Court has found that picking up one’s cane and threatening to hit another with it was sufficient to establish a danger of serious bodily harm. *In re R.D.*, 739 A.2d, 541, Super. 1999, appeal denied 751 A.2d 192, 561 Pa. 699.

¹⁶⁴ Personal anecdote shared with Joint State Government Commission staff by the mother of a young man with a serious mental illness who ultimately murdered his grandmother.

¹⁶⁵ Alaska, Delaware, Kansas, New Jersey, North Dakota, and Washington

¹⁶⁶ http://www.oxforddictionaries.com/us/definition/american_english/debilitate.

¹⁶⁷ Alabama, Alaska, Arizona, Arkansas, Illinois, Louisiana, Maine, Minnesota, North Dakota, Oregon, Texas, Vermont, West Virginia, and Wisconsin.

states in addition to Pennsylvania provide for a specific “look-back” period. Nevada, like Pennsylvania, considers conduct in the past 30 days, while New Hampshire looks at the past 40 days. Colorado and Oregon have similar statutes that consider the nature of the mental illness, lack of treatment, past behavior and prior hospitalizations to determine if dangerous mental deterioration is occurring. Prior hospitalizations occurring within the prior 36 months are considered under these rules.

Assisted Outpatient Treatment

Assisted outpatient treatment (AOT) has been proposed and adopted in a number of states as a means of addressing the needs of persons with serious mental illness by substituting a “need for treatment” standard in lieu of a “dangerousness” standard. Proponents argue that AOT, because it allows for earlier intervention, will cause any necessary hospitalizations to be of shorter duration and the need for hospitalization at all will be decreased.¹⁶⁸ Court-ordered treatment is considered necessary because many persons with mental illness are believed to refuse treatment as a symptom of their illness:

Research shows that at least 40 percent of those diagnosed with schizophrenia and manic-depressive illness lack insight into their illness because of a biologically based symptom known as anosognosia. A person suffering from this symptom does not believe he or she is ill and is likely to refuse treatment reasoning, “why should I take medication if there is nothing wrong with me?” For those who previously refused treatment because of unpleasant or dangerous side-effects of medication, a much broader array of medications is now available so that possible adverse effects of treatment can be more effectively mitigated.¹⁶⁹

The Treatment Advocacy Center (TAC) is a national nonprofit organization that addresses issues related to treatment of severe mental illness. The organization promotes laws, policies, and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder. TAC has developed a Model Law for Assisted Treatment, the centerpiece of which is the concept that many people with serious mental illness are incapable of making an informed medical decision about treatment. If a person is found by the court to be dangerous or incapable of making informed medical decisions because of the effects of severe mental illness, court-ordered assisted treatment may be ordered. Hearing procedures are established, after which a person with mental illness can be ordered to receive inpatient or outpatient treatment. Family members who can show a substantial interest in the proceedings may become a party to the proceedings. A court order for assisted outpatient treatment must include provision for intensive case management, assertive community treatment, or a program for assertive community treatment.

¹⁶⁸ E. Fuller Torrey, M.D., Mary T. Zdanowicz, J.D. and Jonathan Stanley, J.D., “Treatment Advocacy Center Model Law,” <http://www.treatmentadvocacycenter.org/legal-resources/tac-model-law>.

¹⁶⁹ *Ibid.*

An order for assisted outpatient treatment removes an individual's right to refuse treatment, especially medication. An order for assisted treatment, "for its duration, subordinates the individual's right to refuse the administration of medication or other minor medical treatment to the department of mental health, its designee, or any other medical provider obligated to care for the person by the Psychiatric Treatment Board in its order." Instead an individual may be forced to take medication at either the person's residence or a treatment center. "This section offers a non-compliant individual the choice of either accepting medication discreetly in his residence or in the less private, but for some less threatening, setting of a facility designated as a treatment center by the department of mental health or its designee."¹⁷⁰

On December 12, 2013, Congressman Tim Murphy of Pennsylvania introduced H.R. 3717. The "Helping Families in Mental Health Crisis Act of 2013," which is a broad-reaching bill covering multiple aspects of mental health law and which promotes assisted outpatient treatment. It establishes a four-year pilot program to award up to 50 grants each year to counties, cities, mental health systems, mental health courts, and any other entities with authority to implement, monitor, and oversee assisted outpatient treatment. The bill provides that caregivers may be given access to health and educational records in certain circumstances, protects coverage of mental health drugs under Medicare and Medicaid, authorizes a national public awareness campaign to reduce the stigma associated with mental illness, and reauthorizes and revamps SAMHSA. On January 27, 2014, H.R. 3717 was referred to the Subcommittee on Crime, Terrorism, Homeland Security, and Investigations on January 27, 2014.

In Pennsylvania, House Bill No. 550 has been introduced to add assisted outpatient treatment to the Mental Health Procedures Act. The bill was introduced by Representative Mario M. Scavello and referred to the House Committee on Human Services on February 6, 2013.

Among the states that have enacted assisted outpatient treatment, the need for such treatment is usually determined on the basis of the following three criteria:

- An impaired understanding or lack of capacity to appreciate the need for treatment
- A potential to benefit from treatment or a need for treatment or predictable deterioration.
- Predictable deterioration, based upon a history of non-compliance that has resulted in hospitalization or incarceration for violent behavior in a look-back period (typically two or more incidences in the past 36-48 months).¹⁷¹

¹⁷⁰ *Ibid.*, note 155, Comment to Section 10.1.

¹⁷¹ Treatment Advocacy Center, "State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Treatment," January 2013, and "Assisted Psychiatric Treatment: Inpatient and Outpatient Standards by State," June 2011, www.TreatmentAdvocacyCenter.org.

A number of concerns have been expressed about the use of assisted outpatient treatment, with the most vocal revolving around the determination that the person lacks capacity to understand the need for treatment or to even acknowledge the existence of a mental illness. Anosognosia, or “lack of insight,” is the result of brain damage associated with stroke, Alzheimer’s disease, and is some types of schizophrenia.¹⁷² Numerous studies have found that persons with schizophrenia have an impaired ability to appreciate that they are ill, although the percentage of patients with schizophrenia has been found to range from 27% to 97%.¹⁷³ Concerns have been also been expressed regarding the diagnosis of anosognosia. While there is research that shows difference in the brain structure of persons with schizophrenia, there is no definitive brain scan or test that can specifically diagnose anosognosia. The conclusion that a person lacks capacity is ultimately a judicial determination based on a mental health practitioner’s opinion of the patient’s level of obstreperousness. There is the further danger that determinations of “lack of insight” will evolve into an assumption that because a person has a serious mental illness and is refusing treatment, that person is automatically incapable of making a rational decision and should be denied the right to refuse treatment.

The rights to privacy, due process and equal protection have all been raised as objections to AOT. People with life-threatening medical illnesses may refuse treatment for reasons that might appear irrational to some and an exercise of free will to others. While there is a legitimate public interest in protecting others from the dangerous actions of a person with mental illness, protecting individuals from themselves is different. For example, most people would agree that smoking is harmful to the smoker and people in close proximity to smokers (secondhand smoke). Many smokers suffer from nicotine addiction and find it difficult, if not impossible, to stop. Many states have declared smoking a public health issue and have banned smoking in most public places. If lawmakers were to decide to outlaw smoking entirely, could the courts order persons who refuse to quit smoking because of their addiction to use smoking cessation drugs? Or physically force them to use those drugs? If they develop cancer, can they be forced to undergo chemotherapy or radiation, despite objections to the well-known side effects of those treatment modalities?

Additionally, the MHPA currently authorizes involuntary outpatient commitment. Anecdotal evidence suggests that it is rarely ordered because Pennsylvania’s standards for involuntary commitment require a level of dangerousness that usually requires inpatient treatment. When used, involuntary outpatient commitment is usually ordered upon discharge from inpatient treatment in an attempt to ensure that the patient receives follow-up care upon his or her return to the community.¹⁷⁴

¹⁷² E. Fuller Torrey, M.D., “Anosognosia, Denial and the New Anti-Psychiatry,” The Treatment Advocacy Center, <http://www.treatmentadvocacycenter.org/problem/anosognosia/2178>.

¹⁷³ MacArthur Research Network on Mental Health and the Law, MacArthur Foundation, “The MacArthur Treatment Competence Study: Executive Summary,” updated May 2004 and Paul S. Appelbaum and Thomas Grisso, “The MacArthur Treatment Competence Study: I. Mental illness and competence to consent to treatment,” *Law and Human Behavior*, 19, 105-126, 1995.

¹⁷⁴ Telephone conference with Department of Public Welfare and OMHSAS staff, March 14, 2014.

Many family members of persons with serious mental illness have testified in numerous public forums about their frustrations in not being able to obtain treatment for their loved one who is clearly deteriorating mentally, but does not qualify for involuntary treatment until they have become desperately ill. Some of these people see assisted outpatient treatment as a means of obtaining help at an earlier stage. While strengthening the community mental health system can provide earlier intervention and diversion for many of these people, there does appear to be a legitimate need to slightly broaden in involuntary commitment criteria associated with danger to self.

Predicting when a person with serious mental illness is about to become a danger to self or others is very difficult. It is usually based upon past behavior, and in Pennsylvania, a very narrow 30-day look-back period of behavior is considered in determining a need for involuntary commitment. Many AOT statutes look at past episodes resulting in involuntary treatment or incarceration, usually for a period of 3-4 years. The federal definition of “serious mental illness” looks at the person’s treatment history. Treatment history fitting the definition includes either psychiatric treatment more intensive than outpatient care more than once in the past two years or, within the past two years, due to the mental disorder, an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.¹⁷⁵

The proposed codification of the MHPA contained in this report amends the definition of dangerousness in several minute ways. The definition of danger to others is amended to include causing substantial property damage as behavior that may result in involuntary treatment. Danger to self through self-neglect is modified in two ways: (1) to include mental as well as physical deterioration as a possible result of self-neglect, and (2) to broaden the “look-back” period to determine a pattern of behavior that will likely result in the person becoming a danger to self within the next 30 days. It is hoped that these relatively minor adjustments will aid families in obtaining assistance at an earlier stage for mentally ill loved ones who are experiencing a downward spiral, but will not “open the floodgates” to such a degree as to overwhelm an already stressed mental health system.

Duty to Protect

A mental health professional has a duty to warn a third party of potential harm by the professional’s patient where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a specifically identified or readily identifiable victim (subject to the standard of care of the profession).¹⁷⁶ This standard does not always reach the level of dangerous required for involuntary commitment, but is designed as a public safety protection.

¹⁷⁵ 42 CFR § 483.102(b)(1)(iii)

¹⁷⁶ *Emerich v. Philadelphia Center for Human Development, Inc.* 554 Pa. 209, 720 A.2d 1032 (1998).

Under the Mental Health Procedures Act regulations, nonconsensual release of information is authorized in certain circumstances. “Records concerning persons receiving or having received treatment shall be kept confidential and shall not be released nor their content disclosed without the consent of a person given under § 5100.34 (relating to consensual release to third parties), except that relevant portions or summaries may be released or copied as follows: . . . In response to an emergency medical situation when release of information is necessary to prevent serious risk of bodily harm or death. Only specific information pertinent to the relief of the emergency may be released on a nonconsensual basis.”¹⁷⁷ This regulation has been interpreted to include situations in which psychiatric patient’s threats to harm a third party are disclosed.¹⁷⁸

Due to the genesis of the “duty to warn” rule as a holding in a lawsuit, the duty as currently stated does not provide much guidance as to its interpretation. Additionally, mental health professionals are sometimes hesitant to issue a warning because of concerns about potential violations of federal and state privacy laws and liability for failure to issue a warning or for issuing an unfounded warning. Twenty-four states have statutorily mandated a duty to warn/protect regarding the violent propensities of certain mentally ill individuals.¹⁷⁹ The JSGC’s Violence Prevention Advisory Committee¹⁸⁰ recommended that setting forth this duty in a statute would provide better clarity and guidance to persons required to interpret the rule. This proposal is reiterated in this report.¹⁸¹

Under this proposal, mental health professionals, defined as any person licensed by the Pennsylvania Department of State in any mental health related field, shall have a duty to protect individuals and the public from the threat of danger presented by a person receiving behavioral or mental health treatment if all the following circumstances apply:

- The person has communicated an explicit threat of imminent serious physical harm or death to an identified or identifiable victim or the general public.
- The professional reasonably believes, or by the standards of his profession, should believe, that the person has the intent and ability to carry out the threat.
- The threat has been communicated while the professional is engaged in his professional duties.

¹⁷⁷ 55 Pa.Code § 5100.32(a)(9).

¹⁷⁸ *Ms. B. v. Montgomery County Emergency Service*, 799 F.Supp. 534 (E.D. Pa. 1992), *affirmed*, 989 F.2d 488 (3d Cir. Pa. 1993); *cert. denied*, 510 U. S. 860 (U. S. 1993).

¹⁷⁹ Alabama, Arizona, California, Colorado, Delaware, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Tennessee, Utah, Virginia and Washington.

¹⁸⁰ The Violence Prevention Advisory Committee formed under (2012) Senate Resolution 6 issued its final in December 2013.

¹⁸¹ The proposed amendment to the MHPA to codify this duty, which the Advisory Committee prefers to refer to as a “duty to protect” is included in the codification of the MHPA found in this report.

Generally, a professional is expected to look at the totality of the circumstances surrounding the threat in determining whether notice should be given and other appropriate responses.

In fulfilling this duty, a professional may take any precautions that a reasonably prudent professional would take under the circumstances, including communicating the threat to all identified or identifiable victims, notifying a law enforcement agency in the vicinity of where the client or any potential victim resides, or taking reasonable steps to initiate proceedings for voluntary or involuntary commitment if appropriate.

A professional who complies with this duty is immune from civil liability. Disclosures made in good faith under this duty are not considered breaches of confidentiality and are declared to be disclosures authorized without consent under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹⁸²

Availability of Psychiatric Inpatient Hospital Beds

Nationwide, the number of psychiatric inpatient hospital beds has decreased, in part a natural consequence of the deinstitutionalization movement. A recent study found that the number of state psychiatric beds has decreased by 14 percent from 2005-2010. By 2010, per capita state psychiatric population in 2010 was at the same level found in 1850, before the asylum movement began. Additionally, 13 states closed 25 percent or more of the total state hospital bed capacity from 2005-2010.¹⁸³

The expectation of deinstitutionalization is that community mental health services will prevent the need for many inpatient hospitalizations. Many persons have opined that community mental health services have been unable to meet the needs of persons with mental illness, and the unavailability of state beds has exacerbated the problem, leading to a number of negative impacts. Increased demands on law enforcement to deal with persons in acute psychiatric crisis, increasing numbers of persons with mental illness being incarcerated, and overcrowded hospital emergency rooms have all been cited as direct results of the elimination of state hospital beds.¹⁸⁴

Emergency room boarding for persons with mental illness has become the focus of much attention. There is no standard definition of boarding, but it has been variously described as waiting in the emergency room for mental health services to become available or a stay of some duration (4 to 24 hours have been cited).¹⁸⁵ The American College of Emergency Physicians (ACEP) conducted a survey of emergency department medical

¹⁸² Pub.L. 104-191.

¹⁸³ E. Fuller Torrey, M.D., Doris A. Fuller, Jeffrey Geller, M.D., Carla Jacobs, and Kristina Ragosta, J.D., "No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals," The Treatment Advocacy Center, July 19, 2012, at page 5.

¹⁸⁴ *Ibid.*, at page 6.

¹⁸⁵ David Bender, Nalini Pande, and Michael Ludwig, "A Literature Review: Psychiatric Boarding," prepared for the Office of Disability, Aging and Long-Term Care Policy, U.S. Department of Health and Human Services, October 29, 2008, <http://aspe.hhs.gov/daltcp/reports/2008/psybdlr.htm>.

directors and found that 79 percent said psychiatric patients were boarded in their emergency rooms. More than 90 percent indicated that they board psychiatric patients every week. Over 60 percent said the boarding time was over four hours, 33 percent said it was over 8 hours, and 6 percent reported over 24 hour boarding periods.¹⁸⁶ The ACEP continues to express concern about psychiatric emergency room boarding. In its 2014 review of state emergency care provisions, the ACEP stated the following:

Boarding and crowding in the emergency department (ED) and the negative effects that these issues have on patient care and outcomes continue to be major concerns in Pennsylvania . . . While state reports indicate that the number of ED visits have increased, Pennsylvania has seen a decrease in the number of EDs, staffed inpatient beds, and psychiatric care beds per population and continues to have a higher-than-average hospital occupancy rate.¹⁸⁷

Concerns about psychiatric boarding in emergency rooms have led to several proposals for a real-time voluntary reporting system that would create a database of available psychiatric beds. The Pennsylvania Medical Society at its annual House of Delegates meeting in October 2013 passed a resolution endorsing the development of such a system. The resolution called for PMS, the Pennsylvania Psychiatric Society, the Pennsylvania Chapter of the American College of Emergency Physicians, the Pennsylvania Department of Health, the Hospital and Healthsystem Association of Pennsylvania, and other interested stakeholders work together to develop the project.¹⁸⁸

The ACEP also recommended development of a state database: “The [C]ommonwealth should adopt a statewide psychiatric bed registry and work closely with hospitals to minimize boarding of admitted patients in EDs.”¹⁸⁹

While in its initial stages, the organizations named in the PMS House of Delegates resolution, as well as representatives of DPW, are discussing the creation of a voluntary psychiatric bed tracking service that would be available to emergency room personnel to determine what beds are available for psychiatric patients within the hospital’s geographic region.¹⁹⁰ Additionally, OMHSAS is investigating the complaints of bed shortages in an attempt to determine where and when shortages are occurring. OMHSAS is examining this question on a system-wide basis and is using mapping and geocoding to determine

¹⁸⁶ American College of Emergency Physicians, ACEP Psychiatric and Substance Abuse Survey 2008.

¹⁸⁷ Report Card Task Force, American College of Emergency Physicians, “America’s Emergency Care Environment, A State-by-State Report Card,” 2014 Edition, at page 93.

¹⁸⁸ Resolution 13-205, Pennsylvania Medical Society House of Delegates, October 26-27, 2013. *See also*, “Pennsylvania Physicians Say Psychiatric Bed Shortage Stressing ERs,” Press Release, Pennsylvania Medical Society, October 27, 2013; Joe Smydo, “Pennsylvania doctors complain of lack of psychiatric beds and seek solutions,” *Pittsburgh Post-Gazette*, November 3, 2013, www.post-gazette.com/news/state/2013/11/4/Mental-caseloads-a-concern-for-M-D-s/stories/201311040118.

¹⁸⁹*Supra*, note 175. *See also*, “Statement: National Emergency Care Report Card Shows Need for Better Pennsylvania Effort on Psychiatric Bed Shortage,” Press Release, Pennsylvania Medical Society, January 16, 2014.

¹⁹⁰ Correspondence from Deborah Ann Shoemaker, Executive Director, Pennsylvania Psychiatric Society, February 11, 2014.

where bed spaces are located and then cross-referencing them for types of beds (e.g., adolescent, geriatric, adult, by diagnosis, etc.).¹⁹¹

The table below shows the number of adult inpatient beds available in Pennsylvania’s state hospital system in 2013.

Table 5
Number of Adult Inpatient Beds in
Pennsylvania’s State Hospital System, 2013

State Hospital	Adult Inpatient Beds	Adult Forensic Inpatient Beds	Sexual Responsibility and Treatment Program (Act 21) Adult Inpatient Beds
Clarks Summit	242		
Danville	180		
Norristown	258	136	
Torrance ¹⁹²	229	97	37
Warren	225		
Wernersville	266		
Totals	1,400	233	37

Source: Data compiled by Joint State Government Commission from Pennsylvania Department of Public Welfare,

<http://www.dpw.state.pa.us/foradults/statehospitals/clarkssummitstatehospital/index.htm>,

<http://www.dpw.state.pa.us/foradults/statehospitals/danvillestatehospital/index.htm>,

<http://www.dpw.state.pa.us/foradults/statehospitals/norristownstatehospital/index.htm>,

<http://www.dpw.state.pa.us/foradults/statehospitals/warrenstatehospital/index.htm>, and

<http://www.dpw.state.pa.us/foradults/statehospitals/wernersvillestatehospital/index.htm>.

See note 10 for source of information on Torrance State Hospital.

The exact number of inpatient psychiatric beds in Pennsylvania on any given day is difficult to ascertain. Hospitals seem to be in a continuous state of flux, with departments and bed censuses evolving to meet the ever-changing needs of their patients. Determining the number of beds reserved for psychiatric patients is part of the ongoing study by OMHSAS as part of its response to concerns about emergency room boarding. It appears, however, that almost all the county mental health/intellectual disability programs have some inpatient capacity in their service area or in an adjoining program. The following list reflects the hospitals and other facilities within each service area that have noted on their websites that they have inpatient psychiatric units or beds. This list is not exclusive, and is limited to those facilities offering care to adults, including geriatric patients and those with co-occurring disorders.

¹⁹¹ *Supra*, note 174.

¹⁹² Numbers for Torrance State Hospital are approximated, based on the maximum occupancy reported from 2009-2013 in Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare, “Pennsylvania State Hospital System Length-of-Stay, Demographics & Diagnoses Report for June 30, 2013,” “Pennsylvania State Hospital System Length-of-Stay, Demographics & Diagnoses Report for June 30, 2012,” “Pennsylvania State Hospital System Length-of-Stay, Demographics & Diagnoses Report for 2010,” and “Pennsylvania State Hospital System Length-of-Stay, Demographics & Diagnoses Report for 2009,” <http://www.dpw.state.pa.us/foradults/statehospitals/>.

Allegheny

Allegheny Valley Hospital
Alle-Kiski Medical Center
Forbes Hospital
Heritage Valley Sewickley
Jefferson Regional Medical Center
Ohio Valley General Hospital
Southwood Psychiatric Hospital
St. Clair Memorial Hospital
UPMC McKeesport
UPMC Mercy
UPMC Presbyterian Shadyside
Western Pennsylvania Hospital
Western Psychiatric Institute and Clinic

Armstrong/Indiana

Armstrong County Memorial Hospital
Indiana Regional Medical Center

Beaver

Heritage Valley Beaver

Bedford/Somerset

Somerset Hospital Center for Health

Berks

Haven Behavioral Health Hospital of
Eastern PA
Reading Hospital and Medical Center

Blair

Altoona Regional Health System
UPMC Altoona

Bradford/Sullivan

Robert Packer Hospital

Bucks

Foundations Behavioral Health
Lower Bucks Hospital
St. Luke's Hospital Quakertown

Butler

Butler Memorial Hospital

Cambria

Conemaugh Memorial Medical Center

Cameron/Elk

Penn Highlands Elk

Carbon/Monroe/Pike

Gnaden Huetten Memorial Hospital
Palmerton Hospital
Pocono Medical Center

Centre

Meadows Psychiatric Center
Mount Nittany Medical Center

Chester

Brandywine Hospital
St. John Vianney Hospital

Clarion

Clarion Psychiatric Center

Clearfield/Jefferson

Penn Highlands Brookville
Penn Highlands Clearfield
Penn Highlands Dubois

Columbia/Montour/Snyder/Union

Berwick Hospital Center
Geisinger Bloomsburg Hospital
Geisinger Medical Center

Crawford

Meadville Medical Center

Cumberland/Perry

Holy Spirit Hospital
Roxbury Treatment Center

Dauphin

Pennsylvania Psychiatric Institute

Delaware

Crozier Chester Memorial Hospital
Main Line Bryn Mawr Hospital
Mercy Fitzgerald

Erie

Corry Memorial Hospital
Millcreek Community Hospital
St. Vincent Health Center

Fayette

Highlands Hospital and Health Center
Uniontown Hospital

Forest/Warren

Warren General Hospital

Franklin/Fulton

Chambersburg Hospital

Greene

Southwest Regional Medical Center

Huntingdon/Juniata/Mifflin

J.C. Blair Hospital
Geisinger – Lewistown Hospital

Lackawanna/Susquehanna

Geisinger – Community Medical Center
Moses Taylor Hospital
Regional Hospital of Scranton

Lancaster

Ephrata Community Hospital
Lancaster General Hospital
Lancaster Regional Medical Center

Lawrence

Ellwood City Hospital
Jameson Memorial Hospital

Lebanon

Philhaven Hospital

Lehigh

Lehigh Valley Hospital - Muhlenberg
Sacred Heart Hospital Allentown
St. Luke's Hospital Bethlehem

Luzerne/Wyoming

First Hospital of Wyoming Valley
Special Care Hospital
Wilkes-Barre General Hospital

Lycoming/Clinton

Divine Providence Hospital
Lock Haven Hospital

McKean

Bradford Regional Medical Center

Mercer

Sharon Regional Health System

Montgomery

Abington Memorial Hospital
Brooke Glen Behavioral Hospital
Eagleville Hospital
Horsham Clinic
Holy Redeemer Hospital and Medical Center
Lansdale Hospital
Main Line Bryn Mawr Hospital
Mercy Suburban Hospital Norristown
Montgomery County Emergency Services
Pottstown Memorial Medical Center
Valley Forge Medical Center and Hospital

Northampton

*St. Luke's Hospital – Anderson Campus is affiliated with St. Luke's Bethlehem in Lehigh County

Northumberland

Sunbury Community Hospital

Philadelphia

Albert Einstein Medical Center
Aria Health Hospital
Belmont Center for Comprehensive Treatment
Fairmount Behavioral Health System
Friends Hospital
Gerard Medical Center
Hahnemann University Hospital
Kirkbride Center
Mercy Hospital of Philadelphia
Penn Presbyterian Medical Center
Pennsylvania Hospital
Roxborough Memorial Hospital
St. Joseph's Hospital
Temple University Hospital
Thomas Jefferson University Hospital

Potter

Cole Memorial Hospital

Schuylkill

Schuylkill Medical Center

Tioga

Soldiers and Sailors Memorial Hospital

Venango

UPMC Northwest

Washington

Monongahela Valley Hospital
Washington Hospital

Wayne

*Wayne Memorial Health System provides outpatient services only

Westmoreland

Latrobe Area Hospital
Westmoreland Regional Hospital

York/Adams

York Hospital

Shortage of Mental Health Professionals

Any attempt to provide additional services to persons with mental illness, or to bring more persons under the umbrella of the MHPA must acknowledge the shortage of mental health professionals both nationwide and in Pennsylvania. In 2009, The Cecil G. Sheps Center for Health Services Research, University of North Carolina, released the results of a study they conducted of mental health professional shortages in the United States.¹⁹³ The study found that over 77 percent of U.S. counties have a severe shortage of mental health professionals, with over half their need unmet. Eight percent of counties had a severe shortage of non-prescribers. Ninety-six percent of counties has at least some unmet need for prescribers.¹⁹⁴ The most severe shortages appear to be in a north-to-south line in the middle of the country, along the eastern side of the Rocky Mountains. In comparison to those states, Pennsylvania's shortages are on the less severe end of the spectrum, although they occur in all mental health-related fields.

Psychiatrists are medical doctors and in Pennsylvania, they are licensed under the State Medical Board and not under a separate governing entity, which makes it slightly hard to break out psychiatric workforce numbers from other medical specialties. In 2010, the statewide rate of physicians practicing direct care per 100,000 population was 214, or 467 patients per physician. The average age of physicians practicing in Pennsylvania was 49.8 years. Males accounted for 71 percent of the practicing physicians, and 77 percent declared themselves to be of white race/ethnicity.¹⁹⁵ Figures for the number of licensed psychiatrists in Pennsylvania range from 1,788¹⁹⁶ to 2,198.¹⁹⁷ Pennsylvania's psychiatrists are older, with 42.6 percent over the age of 60 in 2013.¹⁹⁸

Pennsylvania's Department of State lists 7,500 licensed psychologists,¹⁹⁹ of which approximately 6,000 are active licensees. In general, since 2006, psychologists must have a doctoral level degree in order to be licensed in Pennsylvania. They are not authorized to prescribe medications in Pennsylvania. Within the grouping of licensed psychologists is the subgroup, licensed clinical psychologists, who are psychologists who are trained and

¹⁹³ Kathleen C. Thomas, M.P.H., Ph.D.; Alarn R. Ellis, M.S.W.; Thomas R. Konrad, Ph.D.; Charles E. Holzer, Ph.D.; and Joseph P. Morrissey, Ph.D.; "County-Level Estimates of Mental Health Professional Shortage in the United States," *Psychiatric Services*, October 1, 2009, <http://ps.psychiatryonline.org/article.aspx?articleid=100819>.

¹⁹⁴ In Pennsylvania, only physicians may prescribe drugs; non-prescribers in this context would be non-physicians, which would include non-psychiatrists, psychologists and other mental health professionals, while prescribers would refer to licensed physicians and psychiatrists.

¹⁹⁵ Bureau of Health Planning, Pennsylvania Department of Health, "2010 Pulse of Pennsylvania's Physician and Physician Assistant Workforce," Vol. 4, June 2012, at pages 10-11.

¹⁹⁶ Joe Smydo, "Psychiatrists in short supply nationwide," *Pittsburgh Post-Gazette*, March 16, 2014, <http://www.post-gazette.com/news/health/2014/03/16/Psychiatrists-in-short-supply-nationwide-Pittsburgh/stories/201403160076>, citing the Association of American Medical Colleges.

¹⁹⁷ U.S. News and Work Report Doctor Finder, <http://health.usnews/doctors/psychiatrists>.

¹⁹⁸ *Supra*, note 187.

¹⁹⁹ Bureau of Professional and Occupational Affairs, Pennsylvania Department of State, http://www.licensepa.state.pa.us/SearchResults.aspx?t_web_lookup_is_organization=N&t_web_lookup_profession_name=Psychology&t_web_lookup_license_type_name=Psychologist&t_web_lookup_last_name=&t_web_lookup_first_name=&t_web_lookup_license_no=&t_web_lookup_addr_county=&t_web_lookup_addr_city=&t_web_lookup_addr_state=PA&t_web_lookup_addr_zipcode=.

experienced in the delivery of direct preventive assessment and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at risk of impairment.”²⁰⁰

On March 19, 2014, Governor Corbett signed Act 21, which amended the MHPA to permit licensed psychologists to perform competency evaluations for arrestees for both competency to proceed and lack of criminal responsibility as a defense. The use of licensed psychologists should help alleviate any backlogs in these evaluations due to shortages of psychiatrists. The Consumers’ Continuity of Care Act²⁰¹ permits licensed psychologists to continue to consult and participate in their patients’ care after a patient has been admitted to a hospital. Consistent with these two acts, and the expanding acceptance of licensed psychologists and the increasing professionalism of the specialty, another potential way to address this psychiatrist shortage is to permit licensed clinical psychologists to authorized emergency admissions under section 302 of the MHPA. Currently, this ability is limited to physicians. A licensed clinical psychologist would be expected to have the experience necessary to determine if a patient is a danger to self or others, and thus in need of emergency evaluation and treatment.

On any given day, the classified section of the newspaper lists multiple openings for front-line human services employees, including mental health caseworkers and managers. These posts are frequently filled with recent college graduates, who may or may not have education or experience in providing mental health services, and have low starting salaries. Employees stay for a few years, and then move on to better paying, less stressful jobs.²⁰²

Student loan forgiveness programs have been discussed as ways to alleviate shortages of trained mental health professionals in county human services programs. These programs and similar programs have successfully provided needed medical personnel in underserved areas. Until recently, similar incentives were granted to physicians who agreed to serve in rural, medically-underserved communities under the federal Public Health Act. The U.S. military has long paid for the education of doctors and dentists in exchange for a set number of years of service. For example, 2013 House Bill No. 1557, Printer’s Number 2094 establishes a student loan forgiveness program in the Pennsylvania Higher Education Assistance Agency, with caps on the total amount of loans that can be forgiven and the number of years of service required. A program like that proposed under this bill could slow down the revolving door that currently exists for the workforce in county human services.

²⁰⁰ 55 Pa.Code § 5100.2.

²⁰¹ *Supra*, note 42.

²⁰² Complaints of this type have been heard from numerous non-profit human services providers.

AREAS OF CONCERN: THE CRIMINAL JUSTICE SYSTEM

The treatment of persons with mental illness encountering the criminal justice system has been the subject of much attention and debate during the past few years. Problems within the Pennsylvania Department of Corrections (DOC) led to a U.S. Department of Justice (DOJ) investigation into the use of solitary confinement for prisoners with mental illness. While the DOC is making strides to ameliorate the problems identified by the DOJ, further efforts are needed to prevent Pennsylvania's jails and prisons from becoming de facto mental institutions. A recent approach, described as the sequential intercept model, attempts to identify five different stages in the criminal justice system where steps could be taken to "intercept" an individual with mental illness and divert them from prolonged incarceration.²⁰³

U.S. Department of Justice Investigation

On December 1, 2011, the DOJ announced that it would be investigating conditions at SCI Cresson and SCI Pittsburgh under the Civil Rights of Institutionalized Persons Act (CRIPA).²⁰⁴ DOJ announced that it would investigate allegations that SCI Pittsburgh failed to adequately protect prisoners from harm, including from prisoner-on-prisoner and officer-on-prisoner violence and sexual violence, in violation of the Eighth Amendment to the U.S. Constitution.²⁰⁵ In addition, it would look into whether SCI Pittsburgh officers systematically targeted prisoners for violence and other abuse based on the prisoners' race, sexual orientation, gender identity, or other status, in violation of the Equal Protection Clause of the 14th Amendment to the U.S. Constitution.²⁰⁶ The investigation of SCI Cresson would address allegations that SCI Cresson provided inadequate mental health

²⁰³ The American Bar Association (ABA) promulgated Criminal Justice Mental Health Standards in 1984. While these could serve as a potential guide to addressing persons with mental illness in the criminal justice system, the Criminal Justice Standards Committee of the Criminal Justice Section of the ABA is currently working to update to those standards. Given that 30 years have elapsed since they were first drafted, the original standards may not be consistent with the current state of either the mental health or criminal justice fields, and new standards may differ dramatically.

²⁰⁴ 42 U.S.C. § 1997.

²⁰⁵ "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Constitution, Amendment VIII,
http://www.archives.gov/exhibits/charters/bill_of_rights_transcript.html.

²⁰⁶ "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Constitution, Amendment XIV, Section 1,
http://www.archives.gov/exhibits/charters/constitution_amendments_11-27.html.

care to prisoners who have mental illness, failed to adequately protect such prisoners from harm, and subjected them to excessively prolonged periods of isolation, in violation of the Eighth Amendment to the U.S. Constitution.²⁰⁷

At the time the SCI Pittsburgh investigation began, DOC had already begun making changes to address the systemic conditions that resulted in the abusive behavior by the corrections officers initially charged in the criminal complaint at SCI Pittsburgh. Accordingly, DOJ deferred issuing findings in order to determine if DOC efforts were sufficient to address their concerns. A final closing letter was issued January 8, 2014, praising the DOC reforms and complimenting Secretary John Wetzel and the DOC for their cooperation and reform of policies and practices, and closing the investigation.²⁰⁸

SCI Cresson did not fare as well under the investigation of the treatment of prisoners with mental illness. DOJ concluded that the manner in which SCI Cresson used isolation on prisoners with serious mental illness violated their Eighth Amendment right to protection from cruel and unusual punishment. Additionally, DOJ found that the use of isolation violated the civil rights of both prisoners with serious mental illness and those with intellectual disabilities under the Americans with Disability Act.²⁰⁹ Although DOC had plans to close SCI Cresson in the summer of 2013,²¹⁰ DOJ, as a result of its investigation, was concerned that the use of isolation at SCI Cresson was not unique within the SCI system, and announced that it was expanding its investigation into all the SCIs statewide.²¹¹

Several deficiencies were identified at SCI Cresson, including the following:

- Mental health staff had been marginalized.
- Mental health considerations were not appropriately accounted for in housing assignments.
- Grossly inadequate mental health care provided in the general population had led to psychiatric deterioration and placement in isolation units.
- In the absence of a functioning secure residential treatment unit, isolation had been used on prisoners with serious mental illness who could not be safely housed in the general population.

²⁰⁷ Civil Rights Division, U.S. Department of Justice, Press Release, “Justice Department Opens Investigations into Two Western Pennsylvania State Correctional Institutions,” December 1, 2011.

²⁰⁸ Civil Rights Division, U.S. Department of Justice, Correspondence to Governor Tom Corbett, Re: Investigation of the State Correctional Institution at Pittsburgh, January 8, 2014, www.justice.gov/crt/about/spl/documents/scip_closingletter_1-8-13.pdf.

²⁰⁹ 42 U.S.C. §§12131-12134.

²¹⁰ SCI Cresson was closed on June 30, 2013.

²¹¹ Civil Rights Division, U.S. Department of Justice, Correspondence to Governor Tom Corbett, Re: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013, www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf.

- Mental health staff and providers have failed to coordinate their efforts.
- Insufficient oversight mechanisms have failed to identify or correct problems.
- Prisoner-on-prisoner abuse had not been properly reviewed.
- Use of force had not been properly reviewed.

With the closing of SCI Cresson, the problems at that particular facility were resolved. However, at the end of its statewide investigation, DOJ found that, although DOC had made numerous improvements in its policies and programs, much additional work would need to be done before a final settlement agreement could be reached between the Commonwealth and the federal government.²¹²

Among the concerns regarding prisoners with serious mental illness that were discussed in the statewide investigation findings letter were the following:

- Solitary confinement involves conditions that are often unjustifiably harsh and in which prisoners with serious mental illness routinely have difficulty obtaining adequate mental health care.
- The use of solitary confinement results in serious harm, including severe mental deterioration, psychotic decompensation and acts of self-harm.
- Numerous systemic deficiencies contribute to the extensive use of solitary confinement. “Too often, instead of providing appropriate mental health care, PDOC’s response to mental illness is to warehouse vulnerable prisoners in solitary confinement cells.”²¹³
- Solitary confinement is unnecessarily and inappropriately used simply because a person has serious mental illness or an intellectual disability.

²¹² Civil Rights Division, U.S. Department of Justice, Correspondence to Governor Tom Corbett, Re: Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities, February 24, 2014, www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf.

²¹³ *Ibid.*, at page 3.

Since the beginning of the SCI Cresson investigation, DOC has made many reforms at all its facilities to address DOJ concerns. Among the reforms and improvements are the following:²¹⁴

- Solitary confinement of prisoners with serious mental illness has declined from 850 persons in 2012 to less than 150 in 2014, as a result of the implementation of more robust misconduct diversionary procedures.
- DOC has partnered with the Vera Institute of Justice as part of its Segregation Reduction Project to develop strategies to safely reduce the use of segregation.
- DOC has updated its definition of serious mental illness to help better identify persons in need of services and connect them to necessary resources.
- DOC has trained over 300 inmates as peer support specialists who can provide support and counseling to other inmates on numerous issues, including participation in mental health treatment.
- Crisis intervention team training has been modified for use by corrections personnel.
- All DOC employees are scheduled to receive mental health first aid training by the end of fiscal year 2014.
- Improved treatment units in the SCIs have been developed.
- DOC has entered a new contract for mental health services in December 2013 with MHM Services that includes performance-based incentives and penalties. Incentives are provided for positive outcomes for offenders and incentivizes treatment that reduces misconduct and mental health recommitment rates.
- DOC has partnered with various advocacy groups and researchers to develop initiatives to improve mental health care.
- Each SCI has established a Suicide Prevention Committee.
- All female inmates received at SCI Muncy will undergo trauma screenings and be connected to appropriate follow-up services.

²¹⁴ Department of Corrections, Commonwealth of Pennsylvania, Press Release, “Pennsylvania Department of Corrections Responds to US Department of Justice Findings Following Review of Mental Health Services,” February 24, 2014, http://www.cor.state.pa.us/portal/server.pt/community/department_of_corrections/4604.

Length of Stay

Inmates with mental illness tend to remain in prison longer than their peers who do not have a mental illness. In part, this can be attributed to a failure to qualify for early release or parole because of behaviors that result in violations of facility rules. Additionally, availability of an inpatient or community placement may delay release.²¹⁵ A three-year study (1999-2002) of Pennsylvania's state prison system found that inmates with mental illness have greater difficulty being release on parole, serve longer prison sentences, and are likely to serve a greater portion of their sentences in prison.²¹⁶ While this may be the case for state prisons, it has not been confirmed in county jails, where sentences are shorter and generally less than two years. A 2003 study of the Philadelphia jail system expressed concerns that similar problems may exist in the county jail systems. "The findings suggest that reentry programs and other jail-based interventions for persons with mental illnesses should ensure that they have the capacity to rapidly identify and service clients with shorter and more unpredictable stays or risk not being responsive to the needs of a substantial proportion of this population."²¹⁷

Under Section 304(g) of the MHPA, a person found incompetent to stand trial or acquitted because of lack of criminal responsibility of certain violent crimes may be subjected to court-ordered involuntary treatment for a period not to exceed one year. An additional year of further treatment may be ordered under the provisions of Section 304(g)(4). A further additional year of treatment may be ordered for such a person under Section 305. This process essentially creates the equivalent of a three-year sentence for the persons subject to these commitment procedures. While this is justifiable in the case of a person who has committed a violent crime, but because of mental illness is held not responsible for the crime, the justification becomes murkier with regard to persons found incompetent to stand trial. With a finding of incompetence, there is no trial and no opportunity for the defendant to present his defense. The person has only been charged with, not convicted of the crime in question, yet a commitment resulting from those charges can result in a maximum three-year deprivation of liberty following minimal due process.

²¹⁵ *Supra* note 9, at page 10.

²¹⁶ Stephen Metraux, Ph.D., "Examining Relationships Between Receiving Mental Health Services in the Pennsylvania Prison System and Time Served," *Psychiatric Services*, July 1, 2008, <http://ps.psychiatryonline.org/article.aspx?articleid=99572>.

²¹⁷ Jeffrey Draine, Ph.D.; Amy Blank Wilson, Ph.D.; Stephen Metraux, Ph.D.; Trevor Hadley, Ph.D.; and Arthur C. Evans, Ph.D.; "The Impact of Mental Illness Status on the Length of Jail Detention and The Legal Mechanism of Jail Release," *Psychiatric Services*, May 1, 2010, <http://ps.psychiatryonline.org/article.aspx?articleid=101355>.

Waiting Lists for Services

Waiting lists are not a new phenomenon in human services. The Joint State Government Commission has been tasked with reviewing several areas of human service programs in the past few years, and waiting lists are a recurring theme.²¹⁸ Department of Public Welfare (DPW) practice has been to complete court-ordered competency evaluations for persons incarcerated in county prisons on an inpatient basis at the Regional Forensic Psychiatric Center at Torrance State Hospital. On an anecdotal basis, this practice has resulted in persons with mental illness who need psychiatric services being held in local jails for lengthy periods of time while waiting for an opening to complete their inpatient evaluation. In response to these concerns, DPW has authorized outpatient competency evaluation services. The Office of Mental Health and Substance Abuse Services (OMHSAS) retains authority to make referrals to a private contractor, Liberty Healthcare Corporation, to complete competency evaluations on an outpatient basis when deemed appropriate. Under this program, assessments must be returned to the originating court within 30 days of the initial referral.²¹⁹

Sequential Intercept Model

While there may always be individuals who are sentenced to prison for the commission of crimes who coincidentally also suffer from mental illness, the population of inmates with serious mental illness in Pennsylvania's county jails and state correctional institutions should not be so large as to overwhelm systems not designed to provide mental health treatment. Many of the problems cited at the DOC facilities are echoed in the community jails. Preventing persons with serious mental illness from being incarcerated in the first place can do much to reduce the strain on correctional facilities and their staff. Since the early 2000s, experts have been calling for greater effort in preventing persons with mental illness from unnecessary and inappropriate contact with the criminal justice system.²²⁰

One method that has been proposed and has proved successful in Pennsylvania is the sequential intercept model. Designed to "divert" persons with mental illness from the criminal justice system and into more appropriate programs and treatments, the model identifies five different stages at which interception and diversion of persons with serious mental illness can occur.

²¹⁸ Joint State Government Commission, the General Assembly of Pennsylvania, "The Advisory Committee Report on the Waiting List for Community-Based Mental Retardation Services," June 2008, http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=22 and "The Effects of Parental Incarceration on Children: Needs and Responsive Services," December 2011, http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=267.

²¹⁹ Bureau of Community and Hospital Operations, Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, Memorandum Re: "Completion of Competency Evaluations," June 17, 2013.

²²⁰ Council of State Governments, "Criminal Justice/Mental Health Consensus Project," June 2002, and the Judge David Bazelon Center for Mental Health Law, "The Role of Mental Health Courts in System Reform," originally published in the *University of the District of Columbia Law Review*, undated.

The Allegheny County Jail Collaborative is a model of all five levels of sequential intercept. Its Community Re-integration Program attempts to address the needs of persons with mental illness in the criminal justice system at each intercept. The program consists of the following elements:

- A screening for inmates to determine service needs.
- A service plan developed through the facilitation of social workers.
- On-going case management support.
- The identification of additional services inside and outside the jail.
- Court commitment to early release for compliance with the service plan.
- Addressing the need for drug and alcohol treatment.
- Planning for aftercare and post-release services well in advance of release.
- Inclusion of the inmate's family when possible.
- Providing services and case management during incarceration and post-release.²²¹

The service plan for the inmate is the keystone of the program. Specific elements must be met in order for the plan to be successful. These elements include:

- Strong, consistent communication among all entities involved.
- Adequate number of jail staff to provide effective case management services.
- On-going planning mechanisms.
- Appropriate and realistic service plans.
- Quality programs with adequate numbers of slots to serve inmates.
- Adequate supervision and support for post-release services.

²²¹ Department of Human Services, Allegheny County, Commonwealth of Pennsylvania, "Offender Re-integration Program/Jail Collaborative," <http://alleghenycounty.us/dhs/jail.aspx>.

- On-going assessment and evaluation of the functioning of the overall service approach and individual programs.

Most of Pennsylvania’s 48 county mental health/intellectual disability programs have services and programs within their service areas at several different intercept levels.

Intercept 1: Law Enforcement and Emergency Services

Intercept 1 looks to encounters between persons with mental illness and law enforcement and emergency services personnel. Crisis intervention programs and training, as well as cross-training for law enforcement personnel in behavioral health issues, are common Intercept 1 approaches.

Crisis Intervention

“Crisis intervention refers to the methods used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems. A crisis can refer to any situation in which the individual perceives a sudden loss of his or her ability to use effective problem-solving and coping skills.”²²² Crisis intervention training can assist law enforcement personnel in recognizing and responding to mental health behaviors that might otherwise be interpreted as criminal misconduct.

Community Crisis Centers have also been suggested as a means of diverting persons with mental illness from emergency rooms and police stations. Allegheny County, in conjunction with the Western Psychiatric Institute and Clinic established the re:solve Crisis Network, a 24-hour, 365-day central crisis intervention service. Individuals can call for assistance, mobile dispatch units can travel anywhere in Allegheny County to assist and individual, and walk-ins are welcome. Residential and/or overnight services are available for up to 72 hours for individuals ages 14 and older whose crisis extends over a period of time. The 150-member crisis team includes crisis intervention-trained psychiatrists, counselors, crisis nurses, crisis service coordinators, and peer support staff.²²³

Another model aims to quickly stabilize persons with less severe symptoms for up to 24 hours. A safe place to sleep, a warm meal, and clean clothes are provided, along with assistance in finding follow-up care. This model has been found to be successful in Billings, Montana, and is under consideration for three cities by the Idaho legislature.²²⁴

²²² Encyclopedia of Mental Disorders, <http://www.minddisorders.com/Br-Del/Crisis-intervention.html>.

²²³ University of Pittsburgh Medical Center, Behavioral Health Services, resolve Crisis Network, <http://www.upmc.com/services/behavioral-health/pages/resolve-crisis-network.aspx>.

²²⁴ The Council of State Governments Justice Center, “Proposed community ‘crisis centers’ would try to keep mentally ill from landing in jails, emergency room,” January 15, 2014, <http://csgjusticecenter.org/mental-health/media-clips/proposed-community-crisis-centers-would-try-to-keep-mentally-ill-from-landing-in-jails-emergency-room/> and Katie Terhune, “Crisis Centers could help Idaho’s mentally ill,” Associated Press article, cited in The Spokesman Review, January 15, 2014, <http://www.spokesman.com/blogs/boise/2014/jan/15/proposed-community-crisis-centers-would-try-keep-mentally-ill-landing-jails-emergency-rooms/>.

Training in Behavioral Health

The Pennsylvania Commission on Crime and Delinquency (PCCD), OMHSAS and the Staunton Farm Foundation in September 2013, announced that that up to \$435,000 in federal, state and private foundation grant money could be used to expand the availability of specialized behavioral health training for law enforcement and juvenile justice practitioners in Pennsylvania and to promote collaboration at the local level.²²⁵

Mental Health First Aid

DOC announced as part of its response to the DOJ investigation of the use of solitary confinement for prisoners with mental illness, that all DOC employees would receive mental health first aid training by the end of fiscal year 2014. Mental health first aid (MHFA) is a nationwide public health education program. The purpose of the program is to improve public responses to early-stage mental illnesses and mental health crises. The program is not intended as a substitute for counseling, medical care or treatment of any kind. MHFA trainings are offered in a variety of settings. The program is designed to educate lay persons on signs and symptoms of various mental disorders, such as depression, anxiety, eating disorders, trauma, psychosis, and deliberate self-injury, and it offers detailed advice on how one can assist in specific situations.

The federal proposed Mental Health First Aid Act of 2013 was introduced in the U.S. House of Representatives and Senate in January 2013 as H.R. 274 and S. 153. States, political subdivisions and nonprofit private entities could apply for grants under the Public Health Service Act to provide training in safe de-escalation of crisis situations, recognition of signs and symptoms of mental illness and timely referral to mental health services. The grants are to be distributed equally geographically across the country, with particular emphasis on rural areas. The Senate version leaves the categories of persons to be trained to be determined by the Secretary of Health and Human Services, while the House version specifies emergency services personnel and other first responders, police officers and other law enforcement personnel, teachers and school administrators, human resources professionals, faith community leaders, nurses and other primary care personnel, students enrolled in elementary and secondary schools and institutions of higher education, parents of those students, veterans, and others as determined appropriate by the Secretary. The sum of \$20 million would be appropriated for fiscal year 2014.

Of the 48 county mental health/intellectual disability programs in Pennsylvania, 42 have either self-identified as providing Intercept 1 services or been identified by the Mental Health and Justice Center of Excellence as providing such services.²²⁶

²²⁵ Pennsylvania Commission on Crime and Delinquency, Commonwealth of Pennsylvania, Memorandum re: "Specialized Behavioral Training for Law Enforcement and Justice Practitioners," September 13, 2013, http://www.portal.state.pa.us/portal/server.pt/document/1379740/specialized_behavioral_health_training_f_or_law_enforcement_and_justice_practitioners_pdf_%282%29.

²²⁶ *Supra* note 62, at page 16, and Mental Health and Justice Center of Excellence, <http://www.pacenterofexcellence.pitt.edu/counties.html>, as of February 11, 2014.

Allegheny	Columbia/Montour/	Lebanon
Armstrong/Indiana	Snyder/Union	Lehigh
Beaver	Cumberland/Perry	Luzerne/Wyoming
Bedford/Somerset	Dauphin	Lycoming/Clinton
Berks	Delaware	Montgomery
Blair	Erie	Northampton
Bradford/Sullivan	Fayette	Northumberland
Bucks	Franklin/Fulton	Philadelphia
Butler	Greene	Schuylkill
Cambria	Huntingdon/Mifflin/	Tioga
Cameron/Elk	Juniata	Venango
Carbon/Monroe/Pike	Lackawanna/	Washington
Centre	Susquehanna	Wayne
Chester	Lancaster	Westmoreland
Clearfield/Jefferson	Lawrence	York/Adams

Intercept 2: Initial Detention and Initial Hearings

The goal of a diversion program at Intercept 2 is to prevent persons with mental illness from becoming more deeply involved in the criminal justice system. Diversions can include conditional bail, deferred prosecution and/or sentencing and pleading guilty with treatment as a condition of parole.²²⁷ Persons with mental illness are identified as such immediately after arrest. With the person’s consent, a comprehensive mental health treatment plan is agreed to and presented to the court, which then can authorize participation in treatment with criminal justice supervision.²²⁸ Thirty-two county programs have been identified as having Intercept 2 services.²²⁹

Allegheny	Cumberland/Perry	Luzerne/Wyoming
Armstrong/Indiana	Dauphin	Lycoming/Clinton
Beaver	Delaware	Montgomery
Bedford/Somerset	Erie	Northampton
Berks	Fayette	Northumberland
Bradford/Sullivan	Franklin/Fulton	Philadelphia
Bucks	Greene	Venango
Cambria	Lancaster	Washington
Carbon/Monroe/Pike	Lebanon	Wayne
Centre	Lehigh	York/Adams

²²⁷ Pennsylvania Department of Public Welfare in collaboration with the Council of State Governments Justice Center, “Developing a statewide, strategic plan to guide Pennsylvania’s response to people with mental illnesses involved with the criminal justice system,” 2008, at page 76.

²²⁸ *Ibid.*, at pages 77-78.

²²⁹ *Supra*, note 215.

Intercept 3: Jail, Courts, Forensic Evaluations, and Forensic Commitments

Intercept 3 services are also provided post-arrest, at the point where the local court becomes involved.

Mental Health Courts

Mental health treatment court is a separate docket maintained by a criminal court to provide court-supervised treatment.²³⁰ Ten essential elements have been identified in order for a mental health treatment court to be successful. The essential elements are as follows:

- Planning and administration. Cross-systems collaboration is crucial, and Pennsylvania's county Criminal Justice Advisory Boards have been cited as an appropriate model.
- Target population. Eligibility must address public safety and the availability of other diversion programs.
- Timely participant identification and linkage to services.
- Terms of participation. Terms must promote public safety, be clear, individualized, and the least restrictive treatment necessary.
- Informed choice. Defendants must fully comprehend the program requirements.
- Treatment supports and services. The courts should use, and help increase the availability of evidence-based services.
- Confidentiality.
- Court team. The team should include criminal justice staff, mental health staff, and service and treatment providers.
- Monitoring adherence to court requirements.
- Sustainability. Performance is periodically assessed, processes are institutionalized, and community support is cultivated and expanded.²³¹

²³⁰ *Supra*, note 216, at page 81.

²³¹ *Ibid.*, at pages 84-85.

Problem-solving courts, including mental health courts, have been officially authorized under Pennsylvania law since 2010,²³² although local jurisdictions had been establishing them for several years prior to the law's enactment. Currently, 15 mental health courts are operational and another five are in development.²³³ The following county programs have access to mental health courts (programs in development are marked with an asterisk).

Allegheny	Erie	Montgomery
Armstrong/Indiana*	Fayette	Northampton*
Berks	Lackawanna/	Philadelphia
Blair*	Susquehanna	Potter
Chester	Lancaster	Venango
Dauphin*	Luzerne/Wyoming	Westmoreland*
Delaware	Lycoming/Clinton	York/Adams

Forensic Peer Support

Forensic peer support specialists are trained to help support offenders at various states in the criminal justice system, from initial contact with law enforcement through community reentry following incarceration. This is a recovery-oriented system that includes ongoing consumer input. Specialists can also promote recovery principles, including self-advocacy, advocate for consumers who cannot advocate for themselves, educate all stakeholders in the criminal justice system about mental health recovery, and inspire hope through shared lived experiences. Pennsylvania has implemented a Statewide Forensic Peer Support Program, which is a collaborative effort of the Drexel University Department of Psychology, The Drexel University's College of Medicine's Department of Psychiatry's Division of Behavioral Healthcare Education, and the Pennsylvania Mental Health Consumers' Association. The program is funded by PCCD and OMHSAS.²³⁴ As of June 14, 2013, DOC has trained 264 inmates as peer specialists, and 13 of the DOC facilities have qualified as a trained facility.²³⁵ DOC and OMHSAS are jointly working to develop a Train the Trainer program to help expand and sustain the Certified Peer Specialist program throughout the State correctional institutions.²³⁶

Eight county programs have been identified as having forensic peer support programs: Armstrong/Indiana, Bedford/Somerset, Blair, Cambria, Centre, Clearfield/Jefferson, Franklin/Fulton, and Philadelphia.

²³² 42 Pa.C.S. § 916, added by the act of June 3, 2010 (P.L.207, No.30).

²³³ *Supra*, note 215. See also, Bill Vidonic, "Butler County wants to set up mental health court," *Pittsburgh Tribune-Review*, February 1, 2014, <http://triblive.com/news/butler/5483987-74/county-mental-court?printerfriendly=true>, and Tom Shortell, *The Express-Times*, "Northampton County Prison study finds specialty courts and community programming key to reducing recidivism," March 19, 2014, http://blog.lehighvalleylive.com/northampton-county_impact/print.html?entry=2014/03/northampton_county_study_finds.html.

²³⁴ Pennsylvania Mental Health & Justice Center of Excellence, "Statewide Forensic Peer Support Program," Final Report, February 2012.

²³⁵ Mary Finck, Reentry Program Manager, "PADOC Certified Peer Support Specialist Initiative Phase II Summary Report," June 27, 2013.

²³⁶ *Supra*, note 85, at pages 30-31.

Intermediate Punishment

County intermediate punishment is a program that provides alternative sentences for persons arrested for non-violent crimes relating to drug and alcohol violations. Individuals in need of drug and alcohol treatment may be sentenced to residential inpatient or residential rehabilitation centers, house arrest with electronic surveillance, or partial confinement in a work release, work camp or halfway facility.²³⁷ Under the statute, “[T]he Pennsylvania Commission on Sentencing shall employ the term ‘eligible offender’ to further identify offenders who would be appropriate for participation in county intermediate punishment programs. In developing the guidelines, the commission shall give primary consideration to protection of the public safety.”²³⁸ While the program is currently limited to persons with substance abuse disorders, it is worth exploring to determine if a similar program could be useful in sentencing offenders with mental illness.

Departure from Mandatory Sentences

Suggestions have been made to allow for departure from mandatory minimum sentences for non-violent offenders with a diagnosed mental illness. 2013 House Bill No. 1799 (Printer’s Number 2587) provides for this type of proposal. While such proposals address the issue of diverting persons from the state’s prisons and jails by imposing shorter sentences, they do not address treatment needs. As a policy matter, it is unclear how authorizing such departures would impact the effectiveness and purpose of mandatory minimum sentences. The subject is worthy of study, but a specific recommendation on how such a program would be implemented is beyond the scope of this study.

Overall, 43 out of 48 county programs maintain some form of Intercept 3 programs. These county programs are listed below:

Allegheny	Cumberland/Perry	Mercer
Armstrong/Indiana	Dauphin	McKean
Beaver	Delaware	Montgomery
Bedford/Somerset	Erie	Northampton
Berks	Fayette	Northumberland
Blair	Franklin/Fulton	Philadelphia
Bradford/Sullivan	Huntingdon/Mifflin/	Potter
Bucks	Juniata	Schuylkill
Cambria	Lackawanna/	Tioga
Cameron/Elk	Susquehanna	Venango
Centre	Lancaster	Washington
Chester	Lawrence	Wayne
Clearfield/Jefferson	Lebanon	Westmoreland
Columbia/Montour/	Lehigh	York/Adams
Snyder/Union	Luzerne/Wyoming	
Crawford	Lycoming/Clinton	

²³⁷ 42 Pa.C.S. Chapter 98.

²³⁸ 42 Pa.C.S. § 3804(b)(2).

Intercept 4: Reentry from Jails, State Prisons, and Forensic Hospitalization

A critical juncture at which intervention can have a significant impact on persons with mental illness is when they are released from jails, state prisons or forensic hospitalizations. The success or failure of a person with mental illness to re-integrate themselves into their home communities post-incarceration depends heavily on the aftercare planning that occurs before their release. The Commonwealth has developed an enhanced reentry protocol for persons being release from state prisons. Specifically, the protocols identify the following steps to be taken:

- DOC identifies inmates receiving treatment for serious mental illness who are either eligible for parole or are within 2 years of being parole eligible.
- A referral packet, consented to by the inmate, is forwarded to the CORE Reentry Committee Group (staffed by representatives of the Pennsylvania Board of Probation and Parole, DOC and DPW).
- The referral packet is reviewed by the individual committee members and a group decision is made at to the appropriateness of enhanced planning for the inmate.
- If the inmate is approved for enhanced planning, the referral is then forwarded to the participating county to invite them to assist in developing a comprehensive home plan for presentation to the parole board.
- Ongoing planning occurs between DOC and the appropriate county representatives until the inmate receives parole and has successfully transitioned back into their community.²³⁹

A similar effort could be made at the county level, by assigning similar pre-release responsibilities to county Criminal Justice Advisory Boards (CJABs). CJAB membership includes top-level representatives of the courts, corrections, law enforcement, community-based organizations, executive branch of government, health and human service agencies, victims' services agencies, and the business and faith communities: they are well suited to develop and coordinate discharge planning for inmates of county jails. Under the minimum operating standards developed by PCCD for CJABs is a requirement to develop and maintain a current strategic plan. Each CJAB is required to develop a reentry component of its strategic plan that calls for collaboration by the CJAB with county jails and state or

²³⁹ "Enhanced Reentry Guidelines," provided via electronic mail on March 17, 2014 from Jessica Reichenbach, Mental Health Program Representative, Office of Mental Health & Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania.

federal prisons, county, state and federal boards of probation and parole, and community and faith-based service providers, for the successful reintegration of offenders.²⁴⁰

One of the more difficult aspects of pre-release planning for inmates involves ensuring that mental health care and treatment will continue uninterrupted after release. Several issues weigh heavily in this outcome: the availability of health insurance (in particular, Medical Assistance), the scheduling of post-release visits with a mental health care provider, and the provision of sufficient psychotropic drugs (if needed) to assure uninterrupted medication until a post-release visit occurs.

Medical Assistance

The federal law establishing Medicaid, called Medical Assistance (MA) in Pennsylvania, prohibits the use of federal funds to pay for services to individuals incarcerated in jails or prisons. “States are not required to terminate Medicaid while individuals are incarcerated. States have the option of keeping individuals on the Medicaid rolls while incarcerated. . . . The advantage of keeping individuals on the Medicaid rolls is that their Medicaid cards and eligibility for services can be restored immediately upon release.”²⁴¹ Pennsylvania regulations call for the immediate termination of MA benefits upon incarceration. “A person in a corrections institution under the supervision and control of the Department of Corrections or in a jail operated by local authorities will be ineligible for MA either as a patient in a hospital of the institution or as a patient in any other hospital.”²⁴² Termination of benefits in many states depends upon the length of stay. Typically, stays in county jails are relatively short, and do not provide sufficient time for an inmate to reapply and complete the MA application before release. Accordingly, a number of states suspend benefits for persons incarcerated for shorter periods. The federal Substance Abuse and Mental Health Administration (SAMSHA) has suggested that sentences of one year or more provide adequate time for a terminated individual to reapply and have benefits restored immediately upon release.²⁴³ Suspension, rather than termination of medical benefits for inmates is also considered a best practice by the Judge David L. Bazelon Center for Mental Health Law.²⁴⁴ Some states are reluctant to adopt suspension, because of concerns about inadvertently violating the federal stricture prohibiting the use of federal funds for inmates. It is safer, from their perspective, to simply terminate benefits, which eliminates that risk. The DOC, PBPP, DPW and the

²⁴⁰ Criminal Justice Advisory Boards, The Pennsylvania Commission on Crime and Delinquency, Commonwealth of Pennsylvania, “Minimum Standards,” Revised January 15, 2013, http://www.portal.state.pa.us/portal/server.pt/community/county_justice_systems/5280/criminal_justice_advisory_boards/493307.

²⁴¹ “The Impact of Incarceration on Medical and Medicare Benefits for People with Mental Illness,” www.nami.org/.../Policy_Medicaid_and_Criminalization_Fact_Sheet.pdf.

²⁴² 55 Pa.Code §§ 161.73 and 161.83.

²⁴³ Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, “Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions,” HHS Publication No. (SMA) 10-4545, Rockville, MD, 2010, at page 14.

²⁴⁴ “Best Practices: Access to Benefits for Prisoners with Mental Illnesses,” A Bazelon Center Issue Brief, <http://www.bazelon.org/News-Publications/Publications/List/1/CategoryID/7/Level/a/ProductID/7.aspx?SortField=ProductNumber,ProductNumber>.

Pennsylvania Department of Drug and Alcohol Programs has established a pilot program at SCI Graterford for persons with substance abuse disorders or co-occurring mental health and substance abuse disorders that assists persons in applying for MA benefits prior to discharge.²⁴⁵

Aftercare

DOC has established continuity of care procedures that allow DOC staff to assist an inmate with mental illness in making aftercare arrangements.²⁴⁶ PBPP has established county reentry programs in York, Berks, and Lackawanna Counties, and is in the process of developing programs in Dauphin, Allegheny, and Philadelphia Counties. These programs are designed to assist persons with mental illness who are about to be paroled with contacting their local mental health/intellectual disability program and connecting with their future case manager before leaving prison.²⁴⁷ A primary aspect of aftercare planning is ensuring that persons who are taking psychotropic drugs for their mental illness are given a sufficient supply to prevent disruption of treatment until a psychiatric appointment occurs.

Prescriptions for Psychotropic Drugs

DOC policy requires that an inmate be provided with a maximum 30 day supply of prescribed medication. A supply for fewer days may be provided if there are overdose concerns or if a psychiatric appointment can be obtained sooner.²⁴⁸ Counties must provide a 48-hour supply of current medications for inmates who are being transferred to the DOC. A similar rule applies for transfers from a DOC facility to a county correctional facility. However, release from a county correctional facility to either State or county probation and parole simply calls for the facility to provide the inmate his current prescriptions as prescribed.²⁴⁹ Prisoners who are released from county jails on psychotropic medications, may receive anywhere from a zero- to 30-day supply of medication, depending upon the county of incarceration.

Zero-day supply: Lackawanna, Lehigh, McKean, Northumberland, Warren, and Westmoreland County jails.

Two-day supply: Clearfield, Greene, Montour, and Washington County jails.

Three-day supply: Adams, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Clarion,

²⁴⁵ Meeting with Leo L. Dunn, Director, Policy and Legislative Affairs, Pennsylvania Board of Probation and Parole, March 4, 2014.

²⁴⁶ Department of Corrections, Commonwealth of Pennsylvania, "Continuity of Care Procedures for an Inmate with Mental Illness Being Discharged", Policy Statement No. 13.8.1, "Access to Mental Health Care," issued May 24, 2004, updated October 25, 2013, at pages 2-14 to 2-21.

²⁴⁷ *Supra*, note 245.

²⁴⁸ *Supra*, note 246, at page 2-18.

²⁴⁹ 42 Pa.C.S. § 9764.

Crawford, Elk, Fayette, Franklin, Huntingdon, Indiana, Jefferson, Lancaster, Lawrence, Mercer, Mifflin, Monroe, Montgomery, Northampton, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Susquehanna, Union, Wayne, and Wyoming County jails.

Five-day supply: Bucks, Chester, Lycoming, Philadelphia, and Tioga County jails.

Seven-day supply: Clinton, Dauphin, Erie, Lebanon, and Luzerne County jails.

14-day supply: Delaware and Venango County jails.

30-day supply: Allegheny, Columbia, Cumberland, and York County jails.²⁵⁰

A two-, three-, five- or even seven-day supply is not likely to be sufficient to provide medication coverage to a patient until the their first psychiatric appointment following discharge. Given the shortage of mental health professionals in Pennsylvania, it is almost guaranteed that there will be a waiting list for appointments. Persons in county jails are not always held long enough to schedule an outpatient visit a month or more in advance while incarcerated. It seems advisable that county jails would serve their inmates with mental illness and the communities that they are about to be released into by providing a lengthier supply of medication, with the ability to give shorter supplies based on the same exceptions granted to the DOC.

A total of 36 county programs report that they have Intercept 4 services available. These county programs include the following:

Allegheny	Clarion	Lawrence
Armstrong/Indiana	Clearfield/Jefferson	Lebanon
Beaver	Cumberland/Perry	Lehigh
Bedford/Somerset	Dauphin	Luzerne/Wyoming
Berks	Delaware	Lycoming/Clinton
Blair	Erie	Mercer
Bradford/Sullivan	Fayette	Montgomery
Bucks	Greene	Philadelphia
Butler	Huntingdon/Mifflin/	Potter
Cambria	Juniata	Schuylkill
Cameron/Elk	Lackawanna/	Westmoreland
Carbon/Monroe/Pike	Susquehanna	York/Adams
Centre	Lancaster	

²⁵⁰ Commonwealth of Pennsylvania, Department of Corrections, County Prisons, Statistics and General Information, “2013 County Statistics,” http://www.cor.state.pa.us/portal/server.pt/community/county_prisons/28063/inspection_schedule_%2C_statistics_and_general_info_/1170613.

Intercept 5: Community Corrections and Community Support

When a person is ready to be released from prison, discharge planning and the availability of community corrections and support play a crucial role in preventing recidivism and relapse. Community corrections apply to a number of persons, including:

- Defendants on pre-trial release.
- Defendants with open cases who have been diverted to a specialty court or program.
- Persons on probation.
- Persons on parole.
- Persons on work release, community service or other intermediate programs.²⁵¹

Community Reentry

In 2012, the General Assembly of Pennsylvania added two new chapters of Title 61 of the Pennsylvania Consolidated States (Prisons and Parole). Chapter 49 establishes the Safe Community Reentry Program for inmates of state and county correctional institutions. DOC and PBPP are jointly responsible for establishing the program. The program is designed to prevent recidivism and ensure successful reentry of offenders into the community. Services and programs may address the educational, employment, housing, and treatment needs of the offender, as appropriate. The DOC or PBPP are to assist each offender in developing a reentry plan. As noted above on page 86, PBPP has established several reentry programs in various counties.

Chapter 50 of Title 61 authorizes the DOC to establish community corrections centers throughout the Commonwealth and contract with private vendors to operate community corrections facilities. Both types of residential entities may house parole violators, offenders serving the community-based portion of a sentence of State intermediate punishment and offenders who have been granted clemency by the Governor.

²⁵¹ Center on Sentencing and Corrections, VERA Institute of Justice, “The Potential of Community Corrections to Improve Safety and Reduce Incarceration,” July 2013, at pages 5-6.

Community Corrections Treatment Services

Offenders with mental illness who are transferred to community corrections by DOC are placed in community contract facilities, group homes designed to provide services to pre-release and parole residents. They receive either on-site programming or case management services with referral to appropriate outpatient mental health services. Mental health services may include comprehensive assessment, psychiatric evaluation and consultation, individual and group counseling, medication compliance, case management, and coordination of treatment services.²⁵²

Housing

Supported housing can do much to provide the stability needed to aid persons with mental illness in recovery. Pennsylvania has a number of programs that support housing opportunities for individuals with mental illness involved in the criminal justice system.²⁵³ Alternative types of housing are needed, such as emergency shelter/crisis residential, transitional or bridge housing, and permanent supportive housing. The type of housing needed can depend on a variety of factors, including various aspects of the individual's personal situation, such as:

- The intercept point at which the person is identified as needing housing.
- Current or previous housing situation.
- Criminal history.
- Family size and household income.
- Credit history.
- Rental history.
- Amount of resources available for security and utility deposits.²⁵⁴

²⁵² Department of Corrections, Commonwealth of Pennsylvania, "Community Corrections Treatment Services," Policy Statement issued May 30, 2012 at page 1-5.

²⁵³ For a fuller discussion of Pennsylvania's efforts at supportive housing, see this report, *infra*, pages 45-46.

²⁵⁴ Diana T. Myers and Associates, Inc., "Housing and the Sequential Intercept Model: A How-to Guide for Planning for the Housing Needs of Individuals with Justice Involvement and Mental Illness," Glenside, PA, March 4, 2010.

Intercept 5 services have been identified in 36 county programs. They include the following:

Allegheny	Columbia/Montour/	Lawrence
Armstrong/Indiana	Snyder/Union	Lebanon
Beaver	Crawford	Lehigh
Bedford	Cumberland/Perry	Luzerne/Wyoming
Berks	Dauphin	Lycoming/Clinton
Bradford/Sullivan	Delaware	Mercer
Bucks	Fayette	McKean
Butler	Forest/Warren	Montgomery
Cambria	Greene	Philadelphia
Cameron/Elk	Huntingdon/Mifflin/	Schuylkill
Centre	Juniata	Venango
Clearfield/Jefferson	Lancaster	Washington
		York/Adams

Other States' Diversion Programs

The Treatment Advocacy Center conducted a study in 2010 to determine what percentage of the population of various states were served by a mental health court or crisis intervention team. Pennsylvania was found to cover 60 percent of its population with mental health courts, and 40 percent with crisis intervention teams. Overall, Pennsylvania ranked 18th among the 50 states. However, among those higher-ranking states were Connecticut and Delaware, which both attained 100 percent coverage in mental health courts, but have much lower scores for crisis intervention teams (Connecticut – 37 percent, Delaware – zero percent). Other similarly skewed states were Nevada, Hawaii, and New York. Conversely, Kentucky, Virginia, and Wisconsin were heavily skewed in favor of crisis intervention teams. Only Utah, Florida, California, and Ohio had high prevalence rates in both areas.²⁵⁵

²⁵⁵ Brian Stettin, Esq., Frederick J. Frese, Ph.D. and H. Richard Lamb, M.D., “Mental Health Diversion Practices, A Survey of the States,” Treatment Advocacy Center, August 2013, pages 8-9.

PROPOSED LEGISLATION

AN ACT

Amending Titles 50 (Mental Health) and 42 (Judiciary and Judicial Procedure) of the Pennsylvania Consolidated Statutes, adding provisions relating to mental health procedures and the treatment of individuals with mental illness in the criminal justice system.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 9764 of Title 42 of the Pennsylvania Consolidated Statutes is amended to read:

§ 9764. Information required upon commitment and subsequent disposition.

* * *

(f) Release from county correctional facility to State probation or parole.--

(1) Prior to the release of an inmate from a county correctional facility to State probation or parole supervision, the facility shall provide to the Board of Probation and Parole the information contained in subsections (a)(1) through (4) and (b).

(2) Prior to the release of an inmate from a county correctional facility to State probation or parole supervision, the facility shall provide to the inmate a 30-day supply of his current medications as prescribed and any customary and necessary medical supplies as determined by the prescribing physician.

(g) Release from county correctional facility to county probation or parole.--

(1) Prior to the release of an inmate from a county correctional facility to county probation or parole supervision, the facility shall provide to the county probation department the information contained in subsections (a)(1) through (4) and (b).

(2) Prior to the release of an inmate from a county correctional facility to county probation or parole supervision, the facility shall provide to the inmate a 30-day supply of his current medications as prescribed and any customary and necessary medical supplies as determined by the prescribing physician.

(g.1) Release from county correctional facility upon completion of sentence.--Prior to the release of an inmate from a county correctional facility upon the completion of the maximum sentence served, the facility shall provide to the inmate a 30-day supply of his current medications as prescribed and any customary and necessary medical supplies as determined by the prescribing physician.

Section 2. Title 50 of the Pennsylvania Consolidated Statutes is amended by adding a new Part III, Mental Health Procedures to read:

TITLE 50

MENTAL HEALTH

Part

III. Mental Health Procedures

PART III

MENTAL HEALTH PROCEDURES

Chapter

31. Preliminary Provisions

32. Voluntary Inpatient Examination and Treatment

33. Involuntary Examination and Treatment

34. Determinations Affecting Those Charged With Crime or Under Sentence

CHAPTER 31

PRELIMINARY PROVISIONS

Subchapter

A. General Provisions

B. Administrative Matters

C. General Treatment Provisions

D. Rights and Immunities

SUBCHAPTER A

GENERAL PROVISIONS

Sec.

3101. Short title.

3102. Definitions.

3103. Statement of policy.

§ 3101. Short title.

This part shall be known and may be cited as the Mental Health Procedures Act of 2014.

Source for § 3101

This section is derived from Section 101 of the act of July 9, 1976, P.L. 817, No. 143, known as the Mental Health Procedures Act (MHPA).

§ 3102. Definitions.

The following words and phrases when used in this part shall have the meanings given to them in this section unless the context clearing indicates otherwise:

“Adequate treatment.” A course of treatment designed and administered to maximize the probability of the person’s recovery from mental illness.

“Authorized person.” A person authorized by the county administrator to perform a specific duty set forth in this part.

“County administrator.” The administrator of a county program or the designee of the administrator.

“County program.” A mental health and intellectual disability program established under Article III of the Act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No. 6) known as the Mental Health and Intellectual Disability Act of 1966.

“Department.” The Pennsylvania Department of Public Welfare.

“Facility.” A mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center or a part of such facility that provides for the diagnosis, treatment, care or rehabilitation of persons with mental illness.

“Incompetent to proceed on criminal charges.” A person who has been charged with a crime who is found to be substantially unable to understand the nature or object of the proceedings against the person or to participate and assist in the person’s own defense.

“Individualized treatment plan” or “treatment plan.” A plan of treatment formulated for a particular person in a program appropriate to the person’s specific needs.

“Inpatient treatment.” Includes all treatment that requires full-time or part-time residence in a facility.

“Licensed clinical psychologist.” A psychologist licensed under the act of March 23, 1972 (P.L.136, No.52) who holds a doctoral degree from an accredited university and is duly trained and experienced in the delivery of direct preventive assessment and therapeutic intervention services to individuals whose growth, adjustment or functioning is actually impaired or demonstrably at risk of impairment.

"Licensed psychologist." An individual licensed under the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act.

"Mental health review officer" or "review officer." A person authorized by a court of common pleas to conduct proceedings under this part.

"Serious mental illness." As defined by the department in its regulations.

"Severely mentally disabled." A condition in which, as a result of mental illness, a person's capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for the person's own personal needs is so lessened that the person poses a clear and present danger of harm to self or others, as determined in section 3301 (relating to persons who may be subject to involuntary emergency examination and treatment).

"Treatment." Includes the following:

(1) Diagnosis, evaluation, therapy or rehabilitation needed to alleviate pain or distress and to facilitate the recovery of a person from mental illness.

(2) Care and other services that supplement treatment described in paragraph (1) and aid or promote the recovery of a person from mental illness.

Source for § 3102

This section new. The definitions of some of the terms are derived from other sections of the MHPA, as follows:

Definition	Source
"adequate treatment"	MHPA § 104
"authorized person"	New
"county administrator"	MHPA § 105
"county program"	MHPA § 105
"department"	MHPA § 105
"facility"	MHPA § 103
"incompetence to proceed on criminal charges"	MHPA § 402(a)

Definition	Source
“individualized treatment plan”	MHPA § 107
“inpatient treatment”	MHPA § 103
“licensed clinical psychologist”	55 Pa.Code § 5100.2
“licensed psychologist”	MHPA §§ 402(h), 404(d)
“mental health review officer”	MHPA § 109(a)
“serious mental illness”	New
“severely mentally disabled”	MHPA § 301(a)
“treatment”	MHPA § 104

§ 3103. Statement of policy.

The purpose of this part is to establish procedures whereby the Commonwealth can seek to assure the availability of adequate treatment to persons with mental illness. The provisions of this part shall be interpreted in conformity with the principles of due process to make voluntary and involuntary treatment available where the need is great and its absence could result in serious harm to the person with mental illness or to others.

Source for § 3103

This 3103 is derived from Section 102 of the MHPA.

SUBCHAPTER B

ADMINISTRATIVE MATTERS

Sec.

3111. Rules and regulations.

3112. Forms.

3113. Confidentiality of records.

3114. Jurisdiction and venue.

3115. Reporting requirements for firearms background checks.

§ 3111. Rules and regulations.

The department shall adopt any rules and regulations necessary to effectuate the provisions of this part. Rules and regulations adopted under the provisions of this part shall be adopted according to provisions of section 201 of act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No.6) the Mental Health and Intellectual Disability Act of 1966, and the act of July 31, 1968 (P.L.769, No.240), known as the Commonwealth Documents Law.

Source for § 3111

This section is derived from Section 112 of the MHPA.

Note to § 3111

Section 201 of the Commonwealth Documents Law (CDL) sets forth the general procedures relating to notice of proposed rulemaking for all agencies:

Section 201. Notice of Proposed Rule Making.--Except as provided in section 204 an agency shall give, in the manner provided in section 405 (relating to additional contents of temporary supplements) public notice of its intention to promulgate, amend or repeal any administrative regulation. Such notice shall include:

(1) The text of the proposed administrative regulation, except any portions thereof omitted pursuant to section 407 (relating to matter not required to be published), prepared in such a manner as to indicate the words to be added or deleted from the presently effective text thereof, if any.

(2) A statement of the statutory or other authority under which the administrative regulation or change therein is proposed to be promulgated.

(3) A brief explanation of the proposed administrative regulation or change therein.

(4) A request for written comments by any interested person concerning the proposed administrative regulation or change therein.

(5) Any other statement required by law.

Section 201 of the Mental Health and Intellectual Disability Act of 1966 (MH/ID Act) provides local authorities with the opportunity for input into any proposed regulations:

**MH/ID Section 201. General Powers and Duties of the Department.--
The department shall have power, and its duty shall be:**

*** * ***

(2) To make, with the advice of the Advisory Committee for Mental Health and Intellectual Disability and enforce all regulations necessary and appropriate to the proper accomplishment of the mental health and intellectual disability duties and functions imposed by this act. Such regulations shall not become effective until the department shall have given the local authorities thirty days written notice of the proposed regulations and afforded the local authorities the opportunity for a hearing before the department on the proposed regulations.

* * *

§ 3112. Forms.

(a) Development.--The department shall establish and adopt forms necessary to effectuate the provisions of this part.

(b) Verification.--A warrant or application under section 3302(a)(2) (relating to involuntary emergency examination and treatment) and each application, petition, and certification required under this part shall be made subject to the penalties provided under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and must contain a notice to that effect.

(c) Submission.--Each warrant, application, petition or certification under subsection (b) must be submitted to the county administrator in the following counties:

(1) Where the person was made subject to examination and treatment.

(2) Any other county in the Commonwealth in which the person is domiciled.

(d) Applicability to voluntary treatment.--Subsections (a) and (b) shall not apply to a person admitted to a treatment facility pursuant to Chapter 32 (relating to voluntary inpatient examination and treatment) when no part of the person's care is provided for with public funds. The department may require facilities to report clinical and statistical information, but the information must not directly or indirectly identify any person who is the subject of the information reported.

Source for § 3112

Subsection (a) is derived from Section 112 of the MHPA. Subsections (b), (c) and (d) are derived from sections 110(a), (b) and (c) of the MHPA.

§ 3113. Confidentiality of records.

(a) Documents in general.--All documents concerning persons in treatment shall be kept confidential and, without the written consent of the person, may not be released or their contents disclosed to anyone except:

(1) Those engaged in providing treatment for the person.

(2) The county administrator, pursuant to section 3112(c) (relating to forms).

(3) A court in the course of legal proceedings authorized by this part.

(4) Pursuant to Federal rules, statutes or regulations governing disclosure of patient information where treatment is undertaken by a Federal agency.

(b) Privileged communications.--Privileged communications, whether written or oral, may not be disclosed to anyone without written consent of the person who made the communication.

(c) Statistical analysis.--Nothing in this section prohibits the collection or analysis of clinical or statistical data by the department, the county administrator or the facility if the use or dissemination of the data does not directly or indirectly identify any person who is the subject of the information reported.

(d) Other law.--Nothing in this section shall be construed to conflict with section 8 of the act of April 14, 1972 (P.L.221, No.63), known as the Pennsylvania Drug and Alcohol Abuse Control Act.

Source for § 3113

This section is derived from subsection 111(a) of the MHPA.

§ 3114. Jurisdiction and venue.

(a) Initial jurisdiction.--The jurisdiction of a court of common pleas or juvenile court conferred by Chapters 32 (relating to voluntary inpatient examination and treatment) and 33 (relating to involuntary examination and treatment) shall be exercised initially by the court for the county in which the subject of the proceedings is located or resides.

(b) Subsequent proceedings.--If involuntary treatment is ordered, jurisdiction over any subsequent proceeding shall be retained by the court in which the initial proceeding occurred, but jurisdiction may be transferred to the county where the person is domiciled.

(c) Proceedings at treatment facility.--The court or a mental health review officer of the county having jurisdiction over the proceedings may conduct legal proceedings at a facility where the person is in treatment, whether or not the facility is located within the county where the court or mental health review officer normally conducts business.

(d) Venue for actions involving statutory rights.--Venue for actions instituted to effectuate rights under this part shall be as now or hereafter provided by law.

Source for § 3114

Subsections (a), (b) and (c) are derived from Section 115(a) of the MHPA. Subsection (d) is derived from Section 115(b) of the MHPA.

§ 3115. Conduct of proceedings.

A proceeding under subsection 3303(c) (relating to extended involuntary emergency treatment), 3304 (relating to court-ordered involuntary treatment), 3305 (relating to additional periods of court-ordered involuntary treatment) and 3306 (relating

to transfer of persons in involuntary treatment) may be conducted by the court or a mental health review officer.

Source for § 3115

This section is derived from Section 109(a) of the MHPA.

§ 3116. Reporting requirements for firearms background checks.

(a) Disclosure for firearms background check purposes.--Notwithstanding other law to the contrary, the court, a mental health review officer and a county administrator shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any of the following persons:

(1) A person who has been adjudicated incompetent to proceed on criminal charges under Chapter 34 (relating to determinations affecting those charged with crime or under sentence).

(2) A person who has been involuntarily committed to a mental institution for inpatient care and treatment under this part.

(3) A person who has been involuntarily treated as described under 18 Pa.C.S. § 6105(c)(4) (relating to persons not to possess, use, manufacture, control, sell or transfer firearms).

(b) Timing of notification.--The notification under subsection (a) shall be transmitted within seven days of the adjudication, commitment or treatment.

(c) Confidentiality provisions waived.--Section 3113 (relating to confidentiality of records) shall not restrict the disclosure of information:

(1) To the Pennsylvania State Police under this section.

(2) By the Pennsylvania State Police from disclosing information to a person in accordance with 18 Pa.C.S. § 6105(c)(4).

Source for § 3116

Subsections (a) and (b) are derived from Section 109(d) of the MHPA. Subsection (c) is derived from Section 111(b) of the MHPA.

Note to § 3116

The last sentence of Section 109(d) of the MHPA is not contained in these statutory provisions; it has been executed and is obsolete transitional language:

Section 109(d) . . . Notwithstanding any statute to the contrary, county mental health and mental retardation administrators shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any individual who before the effective date of this act had been adjudicated incompetent or had been involuntarily committed to a mental institution for inpatient care treatment under this act or had been involuntarily treated as described in 18 Pa.C.S. § 6105(c)(4).

Comment to § 3116

The term “adjudicated incompetent” has been replaced with the language set forth in subsection (a)(1) of this section. Pennsylvania no longer has a procedure to declare an individual “incompetent” or “mentally defective,” although the term “incompetent” remains scattered throughout various provisions of the law. Instead, there are specific procedures to be followed in the situation where a person is adjudicated as “incapacitated.” Under 20 Pa.C.S. § 5501:

“Incapacitated person” means an adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he is partially or totally unable to manage his financial resources or to meet essential requirements for his physical health and safety.

SUBCHAPTER C

GENERAL TREATMENT PROVISIONS

Sec.

3121. Applicability.

3122. Referral of persons discharged from treatment.

3123. Basic treatment requirements.

3124. Treatment facilities.

3125. Treatment team.

3126. Individualized treatment plan.

3127. Periodic reexamination, review and redispotion.

3128. Duty to protect.

§ 3121. Applicability.

(a) Treatment covered.--This part establishes rights and procedures for:

(1) All involuntary inpatient treatment of persons with mental illness.

(2) All involuntary outpatient treatment of persons with mental illness.

(3) All voluntary inpatient treatment of persons with mental illness.

(b) Limitations on treatment.--Treatment shall be delivered subject to the following:

(1) Treatment on a voluntary basis shall be preferred to involuntary treatment.

(2) In every case, the least restrictions consistent with adequate treatment standards shall be employed.

(c) Treatment of individuals with multiple diagnoses.--Individuals who are intellectually disabled, senile, alcoholic or drug dependent shall receive mental health

treatment only if they are also diagnosed as mentally ill, but each of these conditions by itself may not be deemed to constitute mental illness.

(d) Treatment of alcohol abuse or drug addiction.--Nothing in this part shall prohibit underutilized State facilities for the mentally ill to be made available for the treatment of alcohol abuse or drug addiction pursuant to the act of April 14, 1972 (P.L.221, No.63) known as the Pennsylvania Drug and Alcohol Abuse Control Act.

(e) Treatment of chronically disabled elderly persons.--A chronically disabled person who is 70 years of age or older and who has been continuously hospitalized in a State-operated facility for at least ten years is not subject to the procedures of this part. The person's inability to give a rational and informed consent does not prohibit the department from continuing to provide all necessary treatment to the person. If the individual protests treatment or residence at a State- operated facility, that individual shall be subject to the provisions of Chapter 33 (relating to involuntary examination and treatment).

Source for § 3121

Subsection (a) is derived from Section 102 of the MHPA. Subsections (b), (c), (d) and (e) are derived from Section 103 of the MHPA.

§ 3122. Referral of persons discharged from treatment.

(a) Discharge from State institutions.--The facility administration shall refer those voluntary and involuntary patients discharged from State institutional programs to the appropriate county program.

(b) County program responsibilities.--Pursuant to Article III of the act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6) known as the Mental Health and Intellectual Disability Act of 1966County programs shall receive referrals from State-operated facilities and shall be responsible for the treatment needs of county residents discharged from institutions

pursuant to Chapters 32 (relating to voluntary inpatient examination and treatment and 33 (relating to involuntary examination and treatment) of this part.

Source for § 3122

This section is derived from Section 116 of the MHPA.

§ 3123. Basic treatment requirements.

(a) Adequacy.--Adequate treatment shall be provided to all persons in treatment who are subject to this part.

(b) Forms of treatment.--Adequate treatment may include inpatient treatment, partial hospitalization or outpatient treatment.

(c) Adequacy of inpatient treatment.--Adequate inpatient treatment shall include those accommodations, diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as necessary to maintain decent, safe and healthy living conditions.

Source for § 3123

This section is derived from Section 104 of the MHPA.

§ 3124. Treatment facilities.

(a) Approved facilities.--All involuntary and voluntary treatment funded in whole or in part by public moneys shall be available at a facility approved for such purposes by the county administrator or the department. Approval of facilities shall be made by the appropriate authority which can be the department pursuant to regulations adopted by the department.

(b) Veterans facilities.--Treatment may be ordered at the United States Department of Veterans Affairs or other Federal agency upon receipt of a certificate that the person is eligible for such hospitalization or treatment and that there is available space for the person's care. Mental health facilities operated under the direct control of the U.S.

Department of Veterans Affairs or other Federal agency are exempt from obtaining State approval.

(c) Standards for approval.--The department standards for approval shall be at least as stringent as those of the following programs, to the extent that the type of facility is one in which those standards are intended to apply:

(1) The Joint Commission.

(2) Subchapters 18 (relating to health insurance for the aged and disabled) and 19 (relating to grants to states for medical assistance programs) of Chapter 7 of the Social Security Act, 42 U.S.C. §§1395 through 1395kkk-1 and 42 U.S.C. §§ 1396 through 1396w-5).

(d) Exemption.--An exemption from the standards may be granted by the department under the following conditions:

(1) The exemption may be for a period not in excess of one year, which may be renewed.

(2) Notice of each exemption and the rationale for allowing the exemption must be published pursuant to the act of July 31, 1968 (P.L.769, No.240) known as the Commonwealth Documents Law.

(3) Notice of each exemption shall be prominently posted at the entrance to the main office and in the reception areas of the facility.

Source for § 3124

This section is derived from Section 105 of the MHPA.

Note to § 3124

The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in

the United States. The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and prior to that, the Joint Commission on Accreditation of Hospitals (JCAH).

§ 3125. Treatment team.

(a) Leadership.--A treatment team must be under the direction of either of the following:

(1) A licensed clinical psychologist.

(2) A physician if:

(i) failure to do so would jeopardize Federal payments made on behalf of a patient; or

(ii) the director of a facility requires the treatment to be under the direction of a physician.

(b) Composition.--A treatment team must include a physician and may include other mental health professionals.

(c) Independence of professional judgment.--Notwithstanding any other provision of this part, the court or mental health review officer may not specify to the treatment team the adoption of any treatment techniques, modality or drug therapy.

Source for § 3125

Subsection (a) is derived from Sections 106(b) and (c) of the MHPA.

Subsection (b) is derived from Sections 106(b) and (d) of the MHPA.

Subsection (c) is derived from Section 109(c) of the MHPA.

§ 3126. Individualized treatment plan.

(a) Formulation.--A treatment team shall formulate and review an individualized treatment plan for each person who is in treatment under this part.

(b) Basic criteria.--To the extent possible, an individualized treatment plan shall be made with the cooperation, understanding and consent of the person in treatment, and the least restrictions consistent with adequate treatment standards shall be employed.

(c) Administration of drugs.--The administration of drugs shall be controlled by the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act.

Source for § 3126

Subsections (a) and (c) are derived, respectively, from Section 106(a) and (d) of the MHPA. Subsection (b) is derived from Section 107 of the MHPA.

3127. Periodic reexamination, review and redispotion.

(a) Reexamination and review.--

(1) Each person who is in treatment under this part shall be examined by a treatment team.

(2) The person's individualized treatment plan shall be reviewed at lease every 30 days.

(b) Redispotion.--On the basis of reexamination and review, the treatment team may:

(1) authorize continuation of the existing treatment plan if appropriate;

(2) formulate a new individualized treatment plan; or.

(3) recommend to the director the discharge of the person.

(c) Duration or modality of treatment.--A person shall not remain in treatment or under any particular mode of treatment for longer than the treatment is necessary and appropriate to the person's needs.

(d) Record.--The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review under this section for each person in treatment, which shall include all of the following:

(1) A report of the reexamination, including a diagnosis and prognosis.

(2) A brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment.

(3) A statement of the reason for discharge or for continued treatment.

(4) An individualized treatment plan for the next period, if any.

(5) A statement of the reasons that the treatment plan imposes the least restrictions consistent with adequate treatment standards.

(6) A certification that the adequate treatment recommended is available and will be afforded in the treatment program.

Source for § 3127

Subsections (a) and (d) are derived, respectively, from Section 108(a) and (c) of the MHPA. Subsections (b) and (c) are derived from Section 108(b) of the MHPA.

§ 3128. Duty to protect.

(a) Criteria for duty to apply.--In accordance with the procedures under subsection (b), a mental health professional shall attempt to protect each potential victim from a threat of danger from a client of the mental health professional if all of the following apply:

(1) The client has communicated to the mental health professional an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or the general public or a mental health professional reasonably believes after considering the totality of the circumstances that a client of the mental health

professional presents an imminent threat of serious physical harm or death to a clearly identified or identifiable victim or the general public.

(2) The mental health professional reasonably believes, or by the standards of the professional's profession should believe, that the client has the intent and ability to carry out the threat.

(3) The threat has been communicated to the professional by the threatening client while the professional is engaged in his professional duties.

(b) Actions necessary to discharge duty.--A mental health professional may:

(1) use therapeutic interventions or take therapeutic precautions that a reasonable prudent mental health professional would take under the circumstances to diffuse the danger;

(2) communicate the threat to all identified or identifiable victims;

(3) communicate the threat to any individual whose knowledge is likely to protect the health and life of a third party or the public;

(4) notify a law enforcement agency in the vicinity where the client or any potential victim resides; or

(5) take reasonable steps to initiate proceedings for voluntary or involuntary commitment if appropriate.

(c) Immunity from civil liability.--No cause of action shall exist against a mental health professional, and no legal liability may be imposed for breaching a duty to warn of a threat of danger by a client, unless the mental health professional:

(1) fails to comply with this section; and

(2) the failure to comply is the result of an intentional or grossly negligent act or omission that results in harm to a potential victim of the client's threats.

(d) Confidentiality.--

(1) A disclosure made in good faith under this section may not be considered a breach of confidentiality between the mental health professional and the client.

(2) For a mental health professional who is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191, disclosures authorized under this section are declared to be disclosures authorized without the consent of the client under 45 C.F.R. § 164.512(j)(1).

(e) Definitions.--The following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Client." A person receiving behavioral or mental health treatment from a mental health professional.

"Mental health professional." A person licensed or certified in this Commonwealth in any mental health-related field to whom the confidentiality provisions of this act apply.

Source for § 3128

This section is new.

Comment

This provision is to intended to codify the “duty to warn” adopted in *Emerich v. Philadelphia Center for Human Development, Inc.* 720 A.2d 1032 (Pa. 1998). However, it differs from *Emerich* in several significant ways. It includes threats against the general public, outlines how the duty is to be discharged, and adds specific immunity and confidentiality provisions.

The current Mental Health Procedures Act does not have a definitional section. Definitions for the act are provided under regulations. The regulations define a “health professional in mental health” as:

A person who by years of education, training, and experience in mental health settings has achieved professional recognition and standing as defined by their respective discipline, including, but not limited to medicine, social work, psychology, nursing, occupational therapy, recreational therapy, and vocational rehabilitation; and who has obtained if applicable, licensure, registration, or certification. 55 Pa. Code §§ 5100.2, 5210.3 (f).

For purposes of the duty to protect, only those persons with sufficient training and education should bear the responsibility of deciding when to issue a warning.

It is the responsibility of the health care professional to determine whether the threat is credible, which necessarily involves consideration of the use of intoxicants by the person making the threat.

In determining what actions should be taken by a mental health professional under subsection (b), the professional should consider the totality of the circumstances as to the best way to protect the potential victims of the individual’s threats.

Any person who becomes aware of an explicit threat of imminent serious physical harm or death made by an individual against a clearly identified or identifiable victim or the general public may report the threat to local law enforcement, if the person acts in good faith and believes the threat is credible.

SUBCHAPTER D
RIGHTS AND IMMUNITIES

Sec.

3131. Rights and remedies of persons in treatment.

3132. Immunity from civil and criminal liability.

§ 3131. Rights and remedies of persons in treatment.

Each person who is in treatment shall be entitled to all other rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in this part. Actions requesting damages, declaratory judgment, injunction, mandamus, writs of prohibition, habeas corpus, including challenges to the legality of detention or degree of restraint, and any other remedies or relief granted by law, may be maintained in order to protect and effectuate the rights granted under this part.

Source for § 3131

Section 3131 is derived from Section 113 of the MHPA.

§ 3132. Immunity from civil and criminal liability.

(a) Treatment decisions in general.--In the absence of willful misconduct or gross negligence, a county administrator, director of a facility, physician, peace officer, or any other authorized person may not be held civilly or criminally liable for any of the following decisions or the consequences of the decision:

(1) To examine or treat a person under this part.

(2) To discharge a person under this part.

(3) To place a person subject to this part under partial hospitalization, outpatient care or leave of absence.

(4) To reduce a restraint upon a person subject to this part.

(b) Denial of treatment.--A county administrator or other authorized person who denies an application for voluntary treatment or involuntary emergency examination and treatment may not be civilly or criminally liable for the decision or any of its consequences.

(c) Judicial immunity.--A court officer or a mental health review officer shall not be civilly or criminally liable for an action taken or decision made pursuant to the authority conferred by this part.

Source for § 3132

**Subsections (a) and (b) is derived from Section 114(a) of the MHPA.
Subsection (c) is derived from Section 114(b) of the MHPA.**

CHAPTER 32

VOLUNTARY INPATIENT EXAMINATION AND TREATMENT

Sec.

3201. Authorization for voluntary treatment.

3202. Application for voluntary treatment.

3203. Explanation and consent.

3204. Notice to parents.

3205. Physical examination; individualized treatment plan.

3206. Withdrawal from voluntary treatment.

3207. Transfer of person in voluntary treatment.

§ 3201. Authorization for voluntary treatment.

(a) Self-admission.--A person may submit to examination and treatment under this part

if:

(1) The person is 14 years of age or older.

(2) The person believes that treatment is needed.

(3) The person substantially understands the nature of voluntary treatment.

(4) The decision is voluntary

(b) Parental authorization.--A parent, guardian or person standing in loco parentis to a child who is less than 14 years of age may subject the child to examination and treatment under this part and in so doing shall be deemed to be acting for the child.

(c) Applicability.--Except as otherwise authorized in this part, all of the provisions of this part governing examination and treatment shall apply.

Source for § 3201

This section is derived from Section 201 of the MHPA.

§ 3202. Application for voluntary treatment.

(a) To whom application may be made.--An application for voluntary examination and treatment may made to any of the following entities:

(1) An approved facility.

(2) A county administrator.

(3) The U.S. Department of Veterans Affairs.

(4) Any other Federal agency operating a facility for the care and treatment of mental illness.

(b) Designation of treatment facility.--When application is made to the county administrator, the county administrator shall designate the approved facility for examination and treatment as may be appropriate.

Source for § 3202

This section is derived from Section 202 of the MHPA.

§ 3203. Explanation and consent.

(a) Explanation to be given.--Before a person is accepted for voluntary inpatient treatment, an explanation shall be given to the person that includes the following information:

(1) The nature of the treatment, including the types of treatment in which the person may be involved.

(2) Any restraints or restrictions to which the person may be subject.

(3) A statement of the person's rights under this part.

(b) Form of consent.--Consent shall be given in writing upon a form adopted by the department.

(c) Contents of consent.--The consent shall include the following representations:

(1) That the person understands treatment will involve inpatient status.

(2) That the person is willing to be admitted to a designated facility for the purpose of examination and treatment.

(3) That the person consents to the admission voluntarily, without coercion or duress.

(4) If applicable, that the person has voluntarily agreed to remain in treatment for a specified period of no longer than 72 hours after having given written notice of the intent to withdraw from treatment.

(d) Record of consent.--The consent shall be part of the person's record.

Source of § 3203

Section 3203 is derived from Section 203 of the MHPA.

§ 3204. Notice to parents.

(a) Notice.--Upon the acceptance of an application for examination and treatment by a child who is 14 years of age or older but less than 18 years of age, the director of the facility shall promptly notify the child's parents, guardian or person standing in loco parentis to the child to inform them of the right to be heard upon the filing of an objection to the examination and treatment.

(b) Objection to treatment by parent.--Whenever an objection is filed by the parents, guardian or person standing in loco parentis of a child, a hearing shall be held within 72 hours by the court or mental health review officer, to determine whether or not the voluntary treatment is in the best interest of the child.

Source of § 3204

This section is derived from Section 204 of the MHPA.

§ 3205. Physical examination; individualized treatment plan.

(a) Physical examination.--Upon acceptance of a person for voluntary examination and treatment, the person shall be given a physical examination.

(b) Individualized treatment plan.--Within 72 hours after acceptance of a person, a treatment team shall formulate an individualized treatment plan, subject to the following requirements:

(1) The person shall be advised of the treatment plan, which shall become a part of the person's record.

(2) The treatment plan shall state the following:

(i) Whether inpatient treatment is considered necessary.

(ii) What restraints or restrictions, if any, will be administered.

(iii) The bases for the conclusions under subparagraphs (i) and (ii).

Source for § 3205

This section is derived from Section 205 of the MHPA.

§ 3206. Withdrawal from voluntary treatment.

(a) Written notice.--Except as provided in subsections (b) and (c), a person in voluntary inpatient treatment may withdraw at any time by giving written notice of the intent to withdraw from treatment.

(b) Waiting period.--

(1) A person in voluntary inpatient treatment who, pursuant to section 3203(c)(4) (relating to explanation and consent), agreed in writing at the time of admission that release could be delayed for a period specified in the agreement, not to exceed 72 hours, may have that release so delayed.

(2) A person converted from involuntary treatment ordered pursuant to either section 3304 (relating to court-ordered involuntary treatment) or 3305 (relating to additional periods of court-ordered involuntary treatment) to voluntary treatment status shall agree to remain in treatment for 72 hours after giving notice.

(c) Release of children under the age of 14; who may initiate.--If the person is under the age of 14, the parent, legal guardian, or person standing in loco parentis to the child may affect the child's release. If any responsible party believes that it would be in the best interest of a child under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting the least restrictions consistent with adequate treatment standards, that party may file a petition in the Juvenile Division of the court of common

pleas for the county in which the child under 14 years of age resides, requesting a withdrawal from or modification of treatment.

(d) Appointment of counsel; hearing for child under the age of 14.--The court shall promptly appoint an attorney for a child for whom a petition was filed under subsection (b) and schedule a hearing to determine what inpatient treatment, if any, is in the best interest of the child. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for the child. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(e) Lack of medical necessity.--Nothing in this part shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or the designee of the Commissioner.

Source for § 3206

**Subsections (a) and (b) are derived from Section 206(a) of the MHPA.
Subsections (c) and (d) are derived from Section 206(b) of the MHPA.
Subsection (e) is derived from Section 206(c) of the MHPA.**

§ 3207. Transfer of person in voluntary treatment.

A person who is in voluntary treatment may not be transferred from one facility to another without the written consent of the person.

Source for § 3207

This section is derived from section 207 of the MHPA.

CHAPTER 33

INVOLUNTARY EXAMINATION AND TREATMENT

Sec.

3301. Persons who may be subject to involuntary emergency examination and treatment.

3302. Involuntary emergency examination and treatment.

3303. Extended involuntary emergency treatment.

3304. Court-ordered involuntary treatment.

3305. Additional periods of court-ordered involuntary treatment.

3306. Transfer of persons in involuntary treatment.

3307. Appeal of mental health review officer findings.

§ 3301. Persons who may be subject to involuntary emergency examination and treatment.

(a) Applicability.--A person who is severely mentally disabled and in need of immediate treatment may be subject to involuntary emergency examination and treatment. Severely mentally disabled shall include a determination of clear and present danger, as set forth in subsections (b), (c), (d), (e) and (f) of this section.

(b) Determination of clear and present danger of harm to others.-- Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another or caused substantial property damage and that there is a reasonable probability that such conduct will be repeated.

(c) Determination of clear and present danger of harm to self by neglect.--Clear and present of harm to self by neglect shall be shown by both of the following criteria:

(1) Within the past 30 days, the person has acted in such manner as to evidence that the person would be unable, without care, supervision and the continued assistance of others, to satisfy the person's need for nourishment, personal or medical care, shelter or self-protection and safety.

(2) There is a reasonable probability that death, serious bodily injury or serious physical or mental debilitation would ensue within 30 days unless adequate treatment were afforded under this part.

(d) Determination of clear and present danger to self by reoccurrence and relapse.--Clear and present danger of harm to self by reoccurrence and relapse shall be shown by establishing all of the following criteria:

(1) The person has a serious mental illness that has been diagnosed and documented by a psychiatrist.

(2) Within the past 24 months, the person has twice been involuntarily examined and treated under the provisions of this chapter in an approved inpatient facility.

(3) The person is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the inpatient placements referred to in paragraph (2) of this subsection.

(4) There is a reasonable probability that death, serious bodily injury or serious physical or mental debilitation would ensue within 30 days unless adequate treatment were afforded under this part.

(e) Determination of clear and present danger to self by suicide.--Clear and present danger of harm to self by suicide shall be shown by establishing that within the past 30 days, the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this part.

(f) Determination of clear and present danger to self by self-mutilation.--Clear and present danger to self by self-mutilation shall be shown by establishing within the past 30 days, the person has committed substantial self-mutilation or attempted to commit substantial self-mutilation and that there is the reasonable probability of self-mutilation unless adequate treatment is afforded under this part.

(g) Special rule for persons involved in the criminal justice system.--If a person has been found incompetent to proceed on criminal charges or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, the 30-day limitation set forth in subsection (b) shall not apply so long as an application for examination and treatment is filed within 30 days after the date of the incompetency determination or verdict of acquittal. In those cases, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur and that there is a reasonable probability that such conduct will be repeated.

(h) Threats of harm as clear and present danger.--For the purpose of determining a clear and present danger under subsections (b), (e) and (f), a clear and present danger of harm may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

Source for § 3301

Subsection (a) is derived from Section 301(a) of the MHPA. Subsection (b) is derived from the first sentence of paragraph 301(b)(1) of the MHPA. Subsection (c) is derived from Section 201(b)(2)(i) of the MHPA. Subsection (d) is new. Subsection (e) is derived from Section 301(b)(2)(ii) of the MHPA. Subsection (f) is derived from Section 301(b)(2)(iii) of the MHPA. Subsection (g) is derived from the second and third sentences of Section 301(b)(1) of the MHPA. Subsection (h) is derived from the last sentence of Section 301(b)(1), the last sentence of Section 301(b)(2)(ii) and the last sentence of Section 301(b)(2)(iii) of the MHPA.

Comment to § 3301

Subsection (b) differs from its source, Section 301(b) of the MHPA. Causing substantial property damage is added as a means of demonstrating clear and present danger of harm to others. This addition is to acknowledge that there may be instances when a person with mental illness has acted violently, but has not directed that violence at any particular individual. The violence, and the potential for violence, can be just as dangerous when directed at an inanimate object as it is when directed at another human being.

Subsection 3301(d) adds an additional means of determining clear and present danger of harm to self. Persons with a medical and treatment history of serious mental illness who begin to exhibit symptoms or behaviors that have resulted in involuntary inpatient treatment in the past 24 months may receive intervention on an accelerated basis. While predictability of behavior and probability of harm are difficult to ascertain when a person first encounters the mental health system, predictability increases when previous history can be examined as well. The person authorizing examination and treatment may look beyond the immediate past 30 days to attempt to ascertain a pattern of behavior that has led to prior treatment.

Additionally, the potential for mental deterioration may also be considered in the determination of clear and present danger of harm to self in subsections (b) and (c).

§ 3302. Involuntary emergency examination and treatment.

(a) Application for examination.--Emergency examination may be undertaken at a treatment facility based upon any of the following:

- (1) A certification of a physician stating the need for an examination.
- (2) A warrant issued by the county administrator after receipt of a written application by a physician, a licensed clinical psychologist or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment. The county administrator's warrant may require an authorized person or any peace officer to take the person to the facility specified in the warrant.
- (3) Upon personal observation of conduct constituting reasonable grounds to believe that a person is severely mentally disabled and in need of immediate treatment, a physician, licensed clinical psychologist, peace officer, or an authorized person may take the person to an approved facility for an emergency examination without a warrant. Upon arrival, the person who personally observed the conduct shall make a written statement setting forth the grounds for believing the person to be in need of an examination.

(b) Examination and determination of need for treatment.--Emergency examination and treatment shall be conducted as follows:

- (1) A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled and in need of immediate treatment.

(2) If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately.

(3) If the physician does not find the person to be severely mentally disabled and in need of immediate treatment, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to a reasonable location that the person directs.

(4) The physician shall make a record of the examination and findings.

(5) A person may not be accepted for involuntary emergency treatment if a previous application was granted for involuntary emergency treatment and the new application is not based on behavior occurring after the earlier application.

(c) Enforcement of rights at emergency examination.-- Upon arrival at a facility of a person subject to this section, the following shall apply:

(1) The person shall be informed of the reasons for the emergency examination and the right to communicate immediately with others.

(2) The person shall be given reasonable use of the telephone.

(3) The person shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status.

(4) The county administrator or the director of the facility shall:

(i) Give notice to the parties identified in paragraph (3) of the whereabouts and status of the person, how and when contact and visits may be made and how the parties may obtain information concerning the person while in inpatient treatment.

(ii) Take reasonable steps to assure that while the person is detained, the health and safety needs of any of the person's dependents are met and that the person's personal property and the premises the person occupies are secure.

(d) Duration of emergency examination and treatment.--A person who is in treatment pursuant to this section shall be discharged whenever it is determined that the person no longer is in need of treatment, but in all cases within 120 hours of the commencement of treatment, unless within this period either of the following occurs:

(1) The person is admitted to voluntary treatment pursuant to section 3202 (relating to voluntary inpatient treatment).

(2) A certification for extended involuntary emergency treatment is filed pursuant to section 3303 (relating to extended involuntary emergency treatment).

Source for § 3302

Subsection (a)(1) is derived from the first sentence of Section 302(a) of the MHPA. Subsection (a)(2) is derived from the first sentence of Section 302(a) and (a)(1) of the MHPA. Subsection (a)(3) is derived from the first sentence of Section 302(a) and (a)(2) of the MHPA. Subsections (b) and (d) are derived respectively from Section 302(b) and (d) of the MHPA.

Subsection (c)(1), (2) and (3) is derived from the introductory language of Section 302(c) of the MHPA. Subsection (c)(4) is derived from Section 302(c)(1) and (2) of the MHPA.

Comment to § 3302

Paragraphs (2) and (3) of subsection (a) differ from their source in the MHPA in that they authorize a licensed clinical psychologist to obtain an warrant for the emergency examination of an individual, and to escort a person to a treatment facility without a warrant upon personal observation of conduct constituting reasonable grounds to believe that the persons is gravely disabled and in need of immediate treatment. These additions would allow practitioners working with persons with mental health issues to promptly obtain emergency care for their clients. This authority is limited to licensed clinical psychologists, who

have the experience and training to recognize when a person may be suffering from a severe mental disability. These additions are consistent with the duties imposed on mental health professionals under section 3128.

§ 3303. Extended involuntary emergency treatment.

(a) Application.--Application for extended involuntary emergency treatment may be made under the following circumstances:

(1) An application may be made for any person who is being treated pursuant to section 3302 (relating to involuntary emergency examination and treatment) whenever the facility determines that the need for emergency treatment is likely to extend beyond 120 hours.

(2) The application shall be filed in the court of common pleas.

(3) The application shall state the grounds on which extended emergency treatment is believed to be necessary.

(4) The application shall state the name of an examining physician and the substance of the physician's opinion regarding the mental condition of the person.

(b) Appointment of counsel.--Upon receipt of an application under subsection (a), the court shall appoint counsel to represent the person unless appears that the person can afford, and desires to have, private representation.

(c) Procedures.--An informal conference shall be conducted by the court or a mental health review officer within 24 hours after the application is filed, at the facility, if practicable, and subject to the following requirements:

(1) At the commencement of the informal conference, the court or a mental health review officer shall inform the person of the nature of the proceedings.

(2) Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary.

(3) The information presented in paragraph (2) shall be made by a physician who examined the person and shall be in terms understandable to a layman.

(4) The court or mental health review officer may review any relevant information even if it would be normally excluded under rules of evidence if court or mental health review officer believes that the information is reliable.

(5) The person subject to the proceeding or the person's representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information.

(6) A record of the proceedings, which need not be a stenographic record, shall be made. The record shall be kept by the court or mental health review officer for at least one year.

(d) Determination.--At the conclusion of the review set forth in subsection (c), the court or mental health review officer shall make a determination as to whether or not that the person is severely mentally disabled and in need of continued involuntary treatment, subject to the following:

(1) If the person is not severely mentally disabled and in need of continued involuntary treatment, the judge of the court of common pleas or review officer shall direct the director of the facility or his designee to discharge the person.

(2) If the judge of the court of common pleas or review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, a

certification for extended involuntary treatment shall be made subject to the following requirements:

(i) The certification shall be filed with the director of the facility and a copy served on the person, counsel for the person, and such other parties as the person requested to be notified pursuant to section 3302(c)(3).

(ii) Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(e) Form and contents of certification.--The certification shall be made in writing upon a form adopted by the department and shall include the following information:

(1) Findings by the court or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary.

(2) A description of the treatment to be provided, together with an explanation of the adequacy and appropriateness of the treatment, based upon the information received at the informal conference.

(3) Any documents required by 3302.

(4) The application as filed pursuant to subsection (a).

(5) A statement that the person is represented by counsel.

(6) An explanation of the effect of the certification, the person's right to petition the court for release under subsection (f), and the continuing right to be represented by counsel.

(f) Duration.--Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, the person shall be discharged, unless within this period either of the following occurs:

(1) The person is admitted to voluntary treatment pursuant to section 3202.

(2) The court orders involuntary treatment pursuant to section 3304 (relating to court-ordered involuntary treatment).

Source for § 3303

Subsections (a), (e) and (f) are derived from Sections 303(a), (d) and (h) of the MHPA. Subsection (b) is derived from the first sentence of Section 303(b) of the MHPA. The introductory language to subsection (c) is derived from the second sentence of Section 303(b) of the MHPA. Paragraphs (1) through (5) of subsection (c) are derived from the first five sentences of Section 303(c)(1) of the MHPA. Subsection (c)(6) is derived from Section 303(c)(2) of the MHPA. Subsection (d)(1) is derived from the last sentence of Section 303(c)(1) of the MHPA. Subsection (d)(2) is derived from the penultimate sentence of Section 303(c)(1) of the MHPA. Subsection (d)(2)(i) and (ii) is derived from Section 303(e) and (f) of the MHPA.

Comment to §3303

Under Section 302 of the MHPA, the informal conference set forth in subsection (c) is referred to as an “informal hearing” in some places and as an “informal conference” in other places. Given the nature of the proceedings, and in an effort to distinguish this proceeding from other more formal proceedings under this part, the term “informal conference” was used for all references to the proceeding under subsection (c).

§ 3304. Court-ordered involuntary treatment.

(a) Application.--A petition for court-order involuntary treatment may be made for any of the following persons:

(1) A person already subject to treatment under sections 3303 (relating to extended involuntary emergency treatment), 3304 (relating to court-ordered involuntary treatment) or 3305 (relating to additional periods of court-ordered involuntary treatment).

(2) A person who is severely mentally disabled, in need of treatment and determined to be a clear and present danger of harm to self or others under section 3301 (relating to persons who may be subject to involuntary emergency examination and treatment).

(b) Procedures for person already in involuntary treatment.--A petition for court-ordered involuntary treatment under this section may be filed for a person described in paragraph (a)(1) of this section, subject to the following conditions:

(1) The petition may be made to the court by the county administrator or the director of the facility.

(2) The petition shall be in writing upon a form adopted by the department and shall include the following:

(i) A statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment.

(ii) The name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(iii) A statement that the person has been given the information required by paragraph (b)(3).

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, counsel for the person, and those designated to be kept informed as provided in section 3302(c) (relating to involuntary emergency examination and treatment), including an explanation of the nature of the proceedings, the person's right to counsel and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases within five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(6) It shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 3301 in fact occurred and that the person's condition continues to evidence a clear and present danger of harm to self or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

(c) Procedures for persons not already in involuntary treatment.--A petition for court-order involuntary treatment for a person not already in involuntary treatment shall be subject to the following conditions:

(1) Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment.

(2) The petition shall be in writing upon a form adopted by the department and shall set forth the following:

(i) The facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a).

(ii) The name of an examining physician and the substance of the physician's opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint counsel to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that the person can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The following requirements shall apply to the person's appearance for the hearing:

(i) The court may issue a warrant directing an authorized person or a peace officer to bring the person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily.

(ii) A copy of the petition shall be served on the person at least three days before the hearing together with a notice of informing the person of the following:

(A) That counsel has been appointed who shall represent the person unless the person obtains other counsel.

(B) That the person has a right to be assisted in the proceedings by an expert in the field of mental health under subsection (d).

(C) That the person may request or be made subject to psychiatric examination under paragraph (5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court, subject to the following conditions:

(i) The examination shall be conducted on an outpatient basis.

(ii) The person shall have the right to have counsel present.

(iii) A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment may not be authorized during the pendency of a petition except in accordance with section 3302 or section 3033.

(d) Professional assistance.--A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, licensed clinical psychologist or other expert in mental health of the person's choice to assist the person in connection with the hearing and testify on the person's behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for that purpose. The fee shall be a charge against the mental health and intellectual disability program of the county.

(e) Conduct of hearing.--A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and the assistance of an expert in mental health under subsection (d).

(2) The person shall not be called as a witness without the person's consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in the person's own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or the person's counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or the person's counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by the court or a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(f) Standard of proof; treatment alternatives.--

(1) Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or outpatient, or a combination of such treatment as the director of the facility shall from time to time determine.

(2) Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. An order for inpatient treatment shall include findings on the investigation of treatment alternatives, which shall include consideration of the person's relationship to community and family, employment possibilities, all available community resources and guardianship services.

(g) Duration.--

(1) Except as provided in paragraph (2), a person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days.

(2) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if the person meets the both of the following criteria:

(i) The finding of severe mental disability is based on acts giving rise to the under the following provisions of the Pennsylvania Crimes Code:

18 Pa.C.S. § 2502 (relating to murder).

18 Pa.C.S. § 2503 (relating to voluntary manslaughter).

18 Pa.C.S. § 2702 (relating to aggravated assault).

18 Pa.C.S. § 2901 (relating to kidnapping).

18 Pa.C.S. § 3121(1) and (2) (relating to rape).

18 Pa.C.S. § 3121(1) and (2) (relating to involuntary deviate sexual intercourse).

18 Pa.C.S. § 3301 (relating to arson and related offenses).

(ii) A finding of incompetency to proceed on criminal charges or a verdict of acquittal because of lack of criminal responsibility has been entered.

(3) Subject to paragraph (4), if at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), the director shall discharge the person.

(4) No person subjected to involuntary treatment pursuant to paragraph (2) may be discharged without a hearing conducted pursuant to subsection (h).

(h) Hearing.--In cases involving involuntary treatment pursuant to paragraph (g)(2), the following shall apply:

(1) The director shall petition the court which ordered the involuntary treatment for the unconditional or conditional release of the person when either of the following occurs:

(i) The period of court-ordered involuntary treatment is about to expire and neither the director nor the county administrator intends to apply for an additional period of court-ordered involuntary treatment pursuant to section 3305.

(ii) At any time the director concludes that the person is not severely mentally disabled or in need of treatment.

(2) Notice of the petition shall be given to the person, the county administrator and the district attorney of the county where the criminal charges under paragraph (g)(2) were filed.

(3) Within 15 days after the petition has been filed, the court shall hold a hearing to determine if the person is severely mentally disabled and in need of treatment.

(4) Petitions which must be filed simply because the period of involuntary treatment will expire shall be filed at least ten days prior to the expiration of the court-ordered period of involuntary treatment.

(5) If the court determines after hearing that the person is severely mentally disabled and in need of treatment, it may order additional involuntary treatment not to exceed one year. If the court does not so determine, it shall order the discharge of the person.

Source for § 3304

Subsection (a) is derived from Section 304(a)(1) of the MHPA. Paragraphs (1) through (5) of subsection (b) are derived from Section 304(b) of the MHPA. Subsection (b)(6) is derived from Section 304(a)(2) of the MHPA. Subsections (c), (d), (e) and (f) are derived

from Section 304(c), (d), (e) and (f) of the MHPA. Paragraphs (1), (2) and (3) of subsection (g) are derived from Section 304(g)(1), (g)(2) and (g)(3) of the MHPA. Subsection (h) is derived from Section 304(g)(4) of the MHPA.

§ 3305. Additional periods of court-ordered involuntary treatment.

(a) Application.--Upon the application of the county administrator or the director of the facility in which the person is receiving treatment at the expiration of a period of court-ordered involuntary treatment under section 3304(g) (relating to court-ordered involuntary treatment) or this section, the court may order treatment for an additional period.

(b) Basis of order.--The order under subsection (a) shall be entered upon hearing on findings as required for persons already in involuntary treatment by subsection 3304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment.

(c) Duration.--

(1) Except as provided in paragraph (2), the additional period of involuntary treatment shall not exceed 180 days.

(2) Persons meeting the criteria of section 3304(g)(2) may be subject to an additional period of up to one year of involuntary treatment.

(d) Less restrictive alternative placements.--A person found dangerous to self under subsection 3301(c), (d), (e) or (f) (relating to persons who may be subject to involuntary emergency examination and treatment) shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by the court or mental health review officer that such release would not be in the best interests of the person.

(e) Notice.--The director of the facility in which the person is receiving treatment shall notify the county administrator at least ten days prior to the expiration of a period of involuntary commitment ordered under section 3304 or this section.

Source for § 3305

Subsections (a), (b), (c) and (d) are derived from Section 305(a) of the MHPA. Subsection (e) is derived from Section 305(b) of the MHPA.

§ 3306. Transfer of persons in involuntary treatment.

(a) Transfer permitted.--Subject to subsections (b) and (c), a person in involuntary treatment pursuant to this part may be transferred to an approved facility.

(b) Notice.--In the absence of an emergency, persons committed pursuant to section 3304(g)(2) (relating to court-ordered involuntary treatment) may not be transferred unless written notice is given to the court that committed the person and the district attorney in the committing county and no objection is noted from either the court or the district attorney within 20 days of receipt of the notice. If the court or district attorney objects to said transfer, a hearing shall be held by the court within 20 days to review the commitment order. A decision shall be rendered within 48 hours after the close of evidence.

(c) Necessity of transfer.--Whenever a transfer will constitute a greater restraint, it shall not take place unless, upon hearing, the court or review officer finds it to be necessary and appropriate.

Source for § 3306

This s is derived from Section 306 of the MHPA.

§ 3307. Appeal of mental health review officer findings.

In all cases in which a proceeding under subsection 3303(c) (relating to extending involuntary emergency treatment), 3304 (relating to court-ordered involuntary treatment), 3305 (relating to additional periods of court-ordered involuntary treatment) or 3306 (relating to transfer of persons in involuntary treatment) was conducted by a mental health review officer, a person made subject to treatment pursuant to those sections shall have the right to petition the court for review of the certification, subject to the following requirements:

(1) A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel.

(2) The hearing shall include a review of the certification and any evidence as the court may receive or require.

(3) If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this part have been followed, it shall deny the petition. Otherwise, the court shall order the discharge of the person.

Source for § 3307

This section is derived from Sections 109(b) and 303(g) of the MHPA.

CHAPTER 34

DETERMINATIONS AFFECTING THOSE CHARGED WITH CRIME OR
UNDER SENTENCE

Sec.

3401. Examination and treatment of person charged with crime or serving sentence.

3402. Incompetence to proceed on criminal charges.

3403. Incompetency hearing procedures and effect; dismissal of charges.

3404. Determination of criminal responsibility.

3405. Examination of person charged with crime in aid of sentencing.

3406. Application for court-ordered involuntary treatment.

3407. Voluntary treatment for person charged with crime or serving sentence.

§ 3401. Examination and treatment of person charged with crime or serving sentence.

(a) Persons subject to civil provisions.--If a person who is charged with a crime or serving sentence is or becomes mentally disabled, proceedings may be instituted under Chapter 32 (relating to voluntary examination and treatment) or Chapter 33 (relating to involuntary examination and treatment), except that the proceedings shall not affect the conditions of security required by the person's criminal detention or incarceration.

(b) Persons in U.S. Department of Veterans Affairs facilities.--Proceedings under this section shall not be initiated for examination and treatment at a Veterans Affairs facility if either of the following apply:

(1) The examination and treatment requires the preparation of competency reports.

(2) The facility is required to maintain custody and control over the person.

(c) Transfer for examination and treatment.--A person who is detained on criminal charges or incarcerated and made subject to inpatient examination or treatment shall be transferred to a mental health facility for that purpose. Transfer may be made to a Veterans Affairs facility if custody or control is not required in addition to examination and treatment. Individuals transferred to a Veterans Affairs facility are not subject to return by the agency to the authority entitled to have them in custody.

(d) Security provisions.--

(1) During the period of examination and treatment, provisions for the person's security shall continue to be enforced, unless any of the following occurs in the interim:

(i) A pretrial release is affected.

(ii) The term of imprisonment expires or is terminated.

(iii) It is otherwise ordered by the court having jurisdiction over the person's criminal status.

(2) In those instances where a person is charged with offenses listed in section 3304(g)(2) (relating to court-ordered involuntary treatment) and the court, after hearing, deems it desirable, security equivalent to the institution to which the person is incarcerated shall be provided.

(e) Effect of discharge.--Upon discharge from treatment, a person who is or remains subject to a detainer or sentence shall be returned to the authority entitled to have the person in custody. The period of involuntary treatment shall be credited as time served on account of any sentence to be imposed on pending charges or an unexpired term of imprisonment.

(f) Persons Subject to the Juvenile Act.—The provisions of Chapter 33 (relating to involuntary examination and treatment) applicable children of the person’s age shall apply to all proceedings for examination and treatment of a person who is subject to a petition or who has been committed under 42 Pa.C.S. Ch. 63 (relating to juvenile matters). If such a person is in detention or is committed, the court having jurisdiction under 42 Pa.C.S. Ch. 63 shall determine whether the security conditions shall continue to be enforced during any period of involuntary treatment and to whom the person should be released thereafter.

Source for § 3401

Subsections (a) and (b) are derived from Section 401(a) of the MHPA.

Subsections (c), (d) and (e) is derived from Section 401(b) of the MHPA.

Subsection (f) is derived from Section 401(c) of the MHPA.

§ 3402. Incompetence to proceed on criminal charges.

(a) Person incompetent but not severely mentally disabled.--Notwithstanding the provisions of Chapter 33 (relating to involuntary examination and treatment), a court may order involuntary treatment of a person found incompetent to proceed on criminal charges who is not severely mentally disabled subject to the following:

(1) The involuntary treatment shall not exceed 60 days.

(2) Involuntary treatment pursuant to this subsection may be ordered only if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to proceed on criminal charges.

(3) The court may order outpatient treatment, partial hospitalization or inpatient treatment.

(b) Application for incompetency examination.--Application to the court for an order directing an incompetency examination may be presented by any of the following:

(1) An attorney for the Commonwealth.

(2) A person charged with a crime.

(3) Counsel to a person charged with a crime.

(4) The warden or other official in charge of the institution or place in which the person is detained.

(c) Hearing.--

(1) The court, either upon an application under subsection (c) or on its own motion, may order an incompetency examination at any stage in the proceedings and may do so without a hearing unless the person charged with a crime or the person's counsel objects to the examination.

(2) If the person or the person's counsel objects to the examination, an examination shall be ordered only after determination at a hearing that there is a prima facie question of incompetency.

(d) Conduct of examination; report.--When the court orders an incompetency examination:

(1) The examination shall be conducted:

(i) as an outpatient examination unless an inpatient examination is, or has been, authorized under another provision of this part; and

(ii) by at least one psychiatrist or licensed psychologist and may relate both to competency to proceed on criminal charges and to criminal responsibility for the crime charged.

(2) The person shall be entitled to have counsel present and may not be required to answer any questions or to perform tests unless the person has moved for or agreed to

the examination. Nothing said or done by the person during the examination may be used as evidence against the person in any criminal proceedings on any issue other than that of the person's mental condition.

(3) A report shall be submitted to the court and counsel for the person and shall contain a description of the examination, which shall include all of the following:

(i) Diagnosis of the person's mental condition.

(ii) An opinion as to the person's capacity to understand the nature and object of the criminal proceedings against the person and to assist in the person's own defense.

(iii) When so requested, an opinion as to the person's mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning the person's mental condition may also be relevant to the question of legal responsibility.

(iv) When so requested, an opinion as to whether the person had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

(e) Experts.--The court may allow a psychiatrist or licensed psychologist retained by the person and a psychiatrist or licensed psychologist retained by the Commonwealth to witness and participate in the examination of the person. Whenever a person who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist or licensed psychologist, the court shall allow reasonable compensation for the employment of a psychiatrist or licensed psychologist of

the person's selection, which amount shall be chargeable against the mental health and intellectual disability program of the locality.

(f) Time limit on determination.--The determination of the competency of a person who is detained under a criminal charge shall be rendered by the court within 20 days after the receipt of the report of examination unless the hearing was continued at the person's request.

Source for § 3402

Subsections (a) through (f) are derived from Sections 402(b) through (g) of the MHPA.

§ 3403. Incompetency hearing procedures and effect; dismissal of charges.

(a) Standard and burden of proof.--Except for an incompetency examination ordered by the court on its own motion as provided for in section 3402(c) (relating to incompetence to proceed on criminal charges and lack of criminal responsibility as defense), the individual making an application to the court for an order directing an incompetency examination shall have the burden of establishing incompetency to proceed by a preponderance of the evidence. Upon completion of the examination, a determination of incompetency shall be made by the court where incompetency is established by a preponderance of the evidence.

(b) Stay of proceedings.--A determination of incompetency to proceed on criminal charges shall effect a stay of the prosecution for so long as the incompetency persists, subject to the following exceptions:

(1) Any legal objections suitable for determination prior to trial and without the personal participation of the person charged may be raised and decided in the interim.

(2) Except in cases of first and second degree murder, in no instance shall the proceedings be stayed for a period in excess of the maximum sentence of confinement that may be imposed for any crime charged or ten years, whichever is less.

(3) In cases of a charge of first or second degree murder, there shall be no limit on the period during which proceedings may be stayed.

(c) Right to counsel.--A person who is determined to be incompetent to proceed on criminal charges shall have a continuing right to counsel so long as the criminal charges are pending.

(d) Periodic reexamination.--Following a determination of incompetence to proceed on criminal charges, the person charged shall be reexamined not less than every 90 days by a psychiatrist appointed by the court. A report of reexamination shall be submitted to the court and counsel for the person.

(e) Effect on criminal detention.--A determination that a person is incompetent to proceed on criminal charges shall affect criminal detention as follows:

(1) Incompetency to proceed on criminal charges is not sufficient reason on its own to deny the person pretrial release.

(2) The person shall not be detained on the criminal charge longer than the reasonable period of time necessary to determine whether there is a substantial probability that the person will attain competency in the foreseeable future.

(3) If the court determines there is no substantial probability that the person will attain competency, it shall discharge the person.

(4) A person may continue to be criminally detained so long as such substantial probability exists that the person will attain competency, but in no event longer than the period of time specified in subsection (b).

(f) Resumption of proceedings or dismissal.--When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the person, determines that the person has regained his competency to proceed on criminal charges, the proceedings shall be resumed. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged.

(g) Reexamination following discharge.--If the person is discharged pursuant to subsection (e), but the charges remain open pursuant to subsection (b)(2) and (3), the following shall apply:

(1) The court discharging the person shall, on its own motion or on the motion of the Commonwealth or on the motion of the defense, order the person to submit to a psychiatric examination every 12 months after the discharge of the person, to determine whether the person has become competent to proceed to trial.

(2) If the examination under paragraph (1) reveals that the person has regained competency to proceed, a hearing shall be scheduled, after which the court shall determine whether the person is competent to proceed on criminal charges.

(3) If the person is adjudged competent, then trial shall commence within 90 days of the adjudication.

(4) If the examination under paragraph (1) reveals that the person is incompetent to proceed, the court shall order the person to submit to a new competency examination in 12 months.

Source of § 3403

Subsection (a) is derived from Sections 402(d) and 403(a) of the MHPA. The introductory language to subsection (b) is derived from Sections 402(a) and 403(b) of the MHPA. Subsection (b)(1) is derived from Section 403(b) of the MHPA. Subsection (b)(2) and (3) is derived from Section 403(f) of the MHPA. Subsection (c) is derived from Section 402(c) and the first sentence of Section 403(c) of the MHPA. Subsection (d) is derived from second sentence of Section 403(c) of the MHPA. Subsections (e), (f) and (g) are derived respectively from Section 403(d), (e) and (g) of the MHPA.

§ 3404. Determination of criminal responsibility.

(a) Criminal responsibility determination by court.--At a hearing under section 3403 (relating to hearing procedures and effect; dismissal of charges) the court may also hear evidence on whether the person was criminally responsible for the commission of the crime charged, in accordance with the rules governing the consideration and determination of the same issue at criminal trial. If the person is found to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, the person may raise the defense at such time as the person may be tried.

(b) Opinion evidence on mental condition.--At a hearing under section 3403 or upon trial, a psychiatrist or licensed psychologist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant. Each party may also summon any other psychiatrist or licensed psychologist or other expert to testify.

(c) Bifurcation of issues or trial.--Upon trial and in the interest of justice, the court may direct that the issue of criminal responsibility be heard and determined separately from the

other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility, its effect upon other defenses and the probability of a fair trial.

Source for § 3404

This section is derived from Sections 404 of the MHPA.

§ 3405. Examination of person charged with crime as aid in sentencing.

(a) Examination before sentencing.--If a person who has been criminally charged is to be sentenced, the court may defer sentence and order the person to be examined for mental illness to aid in the determination of disposition.

(b) Application for examination.--The action under subsection (a) may be taken on the court's initiative or on the application of the attorney for the Commonwealth, the person charged, the person's counsel, or any other person acting in the person's interest.

(c) Type of examination.--If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to Chapter 33 (relating to involuntary examination and treatment).

Source for § 3405

This section is derived from section 405 of the MHPA.

§ 3406. Application for court-order involuntary treatment.

The attorney for the Commonwealth, on the attorney's own or acting at the direction of the court, the defendant, the defendant's counsel, the county administrator, or any other interested party may petition the same court for an order directing involuntary treatment

under section 3304 (relating to court-ordered involuntary treatment) after the occurrence of any of the following:

(1) A finding of incompetency to proceed on criminal charges under section 3403 (relating to incompetency hearing procedures and effect; dismissal of charges).

(2) An acquittal by reason of lack of criminal responsibility under section 3404 (relating to determination of criminal responsibility).

(3) An examination in aid of sentencing under section 3405 (relating to examination of person charged with crime as aid in sentencing).

Source for § 3406

This section is derived from section 406 of the MHPA.

§ 3407. Voluntary treatment of person charged with crime or serving sentence.

(a) Certification of need.--Whether in lieu of bail or serving a sentence, a person in criminal detention, who believes that the person is in need of treatment and substantially understands the nature of voluntary treatment may submit to examination and treatment under this part, subject to the following certification requirements:

(1) At least one physician shall certify the necessity of treatment and that treatment cannot be adequately provided at the prison or correctional facility where the person then is detained.

(2) The physician's certificate shall set forth the specific grounds that make transfer to a mental health facility necessary.

(3) The correctional facility shall secure a written acceptance of the person for inpatient treatment from the mental health facility and shall forward the acceptance to the court.

(b) Independent examination.--Before any inmate of a prison or correctional facility may be transferred to a mental health facility for the purpose of examination and treatment the correctional facility shall notify the district attorney, who shall be given up to 14 days after receipt of notification to conduct an independent examination of the defendant.

(c) Court review and approval.—The court shall review the certification of the physician that the transfer is necessary and the recommendation of the physician for the Commonwealth and either approve or disapprove the transfer, subject to subsection (d) and the following conditions:

(1) The court may request any other information it needs concerning the necessity of the transfer.

(2) Where possible, the sentencing judge shall preside.

(d) Hearing.--Upon the motion of the district attorney, a hearing shall be held on the question of the voluntary treatment of a person charged with a crime or serving a sentence.

(e) Reports.--A report of the person's mental condition shall be made by the mental health facility to the court within 30 days of the person's transfer to the facility. The report shall also set forth the specific grounds which require continued treatment at a mental health facility. After the initial report, the facility shall thereafter report to the court every 180 days.

(f) Withdrawal from treatment.--If at any time the person gives notice of intent to withdraw from treatment at the mental health facility, the person shall be returned to the authority entitled to have the person in custody, or proceedings may be initiated under section 3304 (relating to court-ordered involuntary treatment). During the pendency of any petition filed under section 3304 concerning a person in treatment under this section the

mental health facility shall have authority to detain the person regardless of the provisions of section 3203 (relating to explanation and consent), provided that the hearing under section 3304 is conducted within seven days of the time the person gives notice of his intent to withdraw from treatment.

(g) Time served.--The period of voluntary treatment under this section shall be credited as time served on account of any sentence to be imposed on pending charges or an unexpired term of imprisonment.

Source for § 3407

Subsections (a), (e), (f) and (g) are derived, respectively, from Sections 407(a), (d), (e) and (f) of the MHPA. Subsection (b) is derived from the first sentence of subsection 407(b) of the MHPA. Subsection (c) is derived from the second sentence of Section 407(b) and Section 407(c) of the MHPA. Subsection (d) is derived from the last sentence of Section 407(b) of the MHPA.

Section 3. The addition of 50 Pa.C.S. Part III is a continuation of the act of July 9, 1976 (P.L.817, No.143) known as the Mental Health Procedures Act. The following apply:

(1) Except as otherwise provided in 50 Pa.C.S. Part III, all activities initiated under the Mental Health Procedures Act shall continue and remain in full force and effect and may be completed under 50 Pa.C.S. Part III. Resolutions, orders, regulations, rules and decisions which were made under the Mental Health Procedures Act and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under 50 Pa.C.S. Part III. Contracts, obligations and agreements entered into under the Mental Health Procedures Act are not affected nor impaired by the repeal of the Mental Health Procedures Act.

(2) Except where specifically commented upon in the report of the Joint State Government Commission entitled "Mental Health Services and the Criminal Justice

System in Pennsylvania” (May 2014), any difference in language between 50 Pa.C.S. Part III and the Mental Health Procedures Act is intended only to conform to the style of the Pennsylvania Consolidated Statutes and is not intended to change or affect the legislative intent, judicial construction or administrative interpretation and implementation of the Mental Health Procedures Act.

(3) A reference in any other act or regulation to the Mental Health Procedures Act shall be deemed to be a reference to 50 Pa.C.S. Part III.

Section 4. Repeals are as follows:

(1) The General Assembly finds that the repeals under paragraph (2) are necessary to effectuate this act.

(2) The act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, is repealed.

Section 5. This act shall take effect in 60 days.

MENTAL HEALTH PROCEDURES ACT (1976)

MENTAL HEALTH PROCEDURES ACT Act of July 9, 1976, P.L. 817, No. 143

Relating to mental health procedures; providing for the treatment and rights of mentally disabled persons, for voluntary and involuntary examination and treatment and for determinations affecting those charged with crime or under sentence.

TABLE OF CONTENTS

Article I. General Provisions

- Section 101. Short Title.
- Section 102. Statement of Policy.
- Section 103. Scope of Act.
- Section 104. Provision for Treatment.
- Section 105. Treatment Facilities.
- Section 106. Persons Responsible for Formulation and Review of Treatment Plan.
- Section 107. Individualized Treatment Plan.
- Section 108. Periodic Reexamination, Review and Redisposition.
- Section 109. Mental Health Review Officer.
- Section 110. Written Applications, Petitions, Statements and Certifications.
- Section 111. Confidentiality of Records.
- Section 112. Rules, Regulations and Forms.
- Section 113. Rights and Remedies of Persons in Treatment.
- Section 114. Immunity from Civil and Criminal Liability.
- Section 115. Venue and Location of Legal Proceedings.
- Section 116. Continuity of Care.

Article II. Voluntary Examination and Treatment

- Section 201. Persons Who May Authorize Voluntary Treatment.
- Section 202. To Whom Application May be Made.
- Section 203. Explanation and Consent.
- Section 204. Notice to Parents.
- Section 205. Physical Examination and Formulation of Individualized Treatment Plan.
- Section 206. Withdrawal from Voluntary Inpatient Treatment.
- Section 207. Transfer of Person in Voluntary Treatment.

Article III. Involuntary Examination and Treatment

- Section 301. Persons Who May be Subject to Involuntary Emergency Examination and Treatment.

Section 302. Involuntary Emergency Examination and Treatment Authorized by a Physician - Not to Exceed One Hundred Twenty Hours.

Section 303. Extended Involuntary Emergency Treatment Certified by a Judge or Mental Health Review Officer - Not to Exceed Twenty Days.

Section 304. Court-ordered Involuntary Treatment Not to Exceed Ninety Days.

Section 305. Additional Periods of Court-ordered Involuntary Treatment.

Section 306. Transfer of Persons in Involuntary Treatment.

Article IV. Determinations Affecting Those Charged With Crime, or Under Sentence

Section 401. Examination and Treatment of a Person Charged with Crime or Serving Sentence.

Section 402. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as Defense.

Section 403. Hearing and Determination of Incompetency to Proceed; Stay of Proceedings; Dismissal of Charges.

Section 404. Hearing and Determination of Criminal Responsibility; Bifurcated Trial.

Section 405. Examination of Person Charged with Crime as Aid in Sentencing.

Section 406. Civil Procedure for Court-ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility or in Conjunction with Sentencing.

Section 407. Voluntary Treatment of a Person Charged with Crime or Serving Sentence.

Section 408. Costs of Treatment.

Article V. Effective Date, Applicability, Repeals and Severability

Section 501. Effective Date and Applicability.

Section 502. Repeals.

Section 503. Severability.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

ARTICLE I
General Provisions

Section 101. Short Title.--This act shall be known and may be cited as the "Mental Health Procedures Act."

Section 102. Statement of Policy.--It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. The provisions of this act shall be interpreted in conformity with the principles of due process to make voluntary and involuntary treatment available where the need is great and its absence could result in serious harm to the mentally ill person or to others. Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health

treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness: Provided, however, That nothing in this act shall prohibit underutilized State facilities for the mentally ill to be made available for the treatment of alcohol abuse or drug addiction pursuant to the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act." Chronically disabled persons 70 years of age or older who have been continuously hospitalized in a State operated facility for at least ten years shall not be subject to the procedures of this act. Such a person's inability to give a rational, informed consent shall not prohibit the department from continuing to provide all necessary treatment to such a person. However, if such a person protests treatment or residence at a State operated facility he shall be subject to the provisions of Article III.

Section 103. Scope of Act.--This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

Section 104. Provision for Treatment.--Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his recovery from mental illness. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions. Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and shall also include care and other services that supplement treatment and aid or promote such recovery.

Section 105. Treatment Facilities.--Involuntary treatment and voluntary treatment funded in whole or in part by public moneys shall be available at a facility approved for such purposes by the county administrator (who shall be the County Mental Health and Mental Retardation Administrator of a county or counties, or his duly authorized delegate), or by the Department of Public Welfare, hereinafter cited as the "department." Approval of facilities shall be made by the appropriate authority which can be the department pursuant to regulations adopted by the department. Treatment may be ordered at the Veterans Administration or other agency of the United States upon receipt of a certificate that the person is eligible for such hospitalization or treatment and that there is available space for his care. Mental health facilities operated under the direct control of the Veterans Administration or other Federal agency are exempt from obtaining State approval. The department's standards for approval shall be at least as stringent as those of the joint commission for accreditation of hospitals and those of the Federal Government pursuant to Titles 18 and 19 of the Federal Social Security Act to the extent that the type of facility is one in which those standards are intended to apply. An exemption from the standards

may be granted by the department for a period not in excess of one year and may be renewed. Notice of each exemption and the rationale for allowing the exemption must be published pursuant to the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law," and shall be prominently posted at the entrance to the main office and in the reception areas of the facility.

Section 106. Persons Responsible for Formulation and Review of Treatment Plan.--

(a) Pursuant to sections 107 and 108 of this act, a treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this act.

(b) A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professionals.

(c) A treatment team must be under the direction of a physician when:

(1) failure to do so would jeopardize Federal payments made on behalf of a patient;
or

(2) the director of a facility requires the treatment to be under the direction of a physician.

(d) All treatment teams must include a physician and the administration of all drugs shall be controlled by the act of April 14, 1972 (P.L.233, No.64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."

Section 107. Individualized Treatment Plan.--Individualized treatment plan means a plan of treatment formulated for a particular person in a program appropriate to his specific needs. To the extent possible, the plan shall be made with the cooperation, understanding and consent of the person in treatment, and shall impose the least restrictive alternative consistent with affording the person adequate treatment for his condition.

Section 108. Periodic Reexamination, Review and Redisposition.--

(a) Reexamination and Review.--Every person who is in treatment under this act shall be examined by a treatment team and his treatment plan reviewed not less than once in every 30 days.

(b) Redisposition.--On the basis of reexamination and review, the treatment team may either authorize continuation of the existing treatment plan if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the person. A person shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his needs.

(c) Record of Reexamination and Review.--The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review under this section for each person in treatment to include:

- (1) a report of the reexamination, including a diagnosis and prognosis;
- (2) a brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment;
- (3) a statement of the reason for discharge or for continued treatment;
- (4) an individualized treatment plan for the next period, if any;
- (5) a statement of the reasons that such treatment plan imposes the least restrictive alternative consistent with adequate treatment of his condition; and
- (6) a certification that the adequate treatment recommended is available and will be afforded in the treatment program.

Section 109. Mental Health Review Officer.--

(a) Legal proceedings concerning extended involuntary emergency treatment under section 303(c), court-ordered involuntary treatment under section 304 or 305 or transfer hearings under section 306, may be conducted by a judge of the court of common pleas or by a mental health review officer authorized by the court to conduct the proceedings.

(b) In all cases in which the hearing is conducted by a mental health review officer, a person made subject to treatment shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(c) Notwithstanding any other provision of this act, no judge or mental health review officer shall specify to the treatment team the adoption of any treatment technique, modality, or drug therapy.

(d) Notwithstanding any statute to the contrary, judges of the courts of common pleas, mental health review officers and county mental health and mental retardation administrators shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any individual who has been adjudicated incompetent or who has been involuntarily committed to a mental institution for inpatient care and treatment under this act or who has been involuntarily treated as described under 18 Pa.C.S. § 6105(c)(4) (relating to persons not to possess, use, manufacture, control, sell or transfer firearms). The notification shall be transmitted by the judge, mental health review officer or county mental health and mental retardation administrator within seven days of the adjudication, commitment or treatment. Notwithstanding any statute to the contrary, county mental health and mental retardation administrators shall notify the Pennsylvania State Police on a form developed by the Pennsylvania State Police of the identity of any individual who before the effective date of this act had been adjudicated incompetent or had been involuntarily committed to a mental institution for inpatient care treatment under this act or had been involuntarily treated as described in 18 Pa.C.S. § 6105(c)(4).

Section 110. Written Applications, Petitions, Statements and Certifications.--

(a) All written statements pursuant to section 302(a)(2), and all applications, petitions, and certifications required under the provisions of this act shall be made subject to the penalties provided under 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and shall contain a notice to that effect.

(b) All such applications, petitions, statements and certifications shall be submitted to the county administrator in the county where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides.

(c) Subsections (a) and (b) shall not apply to patients admitted pursuant to Article II when no part of the patient's care is provided with public funds provided that the department may require facilities to report clinical and statistical information so long as the data does not identify individual patients.

Section 111. Confidentiality of Records.--

(a) All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except:

- (1) those engaged in providing treatment for the person;
- (2) the county administrator, pursuant to section 110;
- (3) a court in the course of legal proceedings authorized by this act; and
- (4) pursuant to Federal rules, statutes and regulations governing disclosure of patient information where treatment is undertaken in a Federal agency.

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent. This shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients. Nothing herein shall be construed to conflict with section 8 of the act of April 14, 1972 (P.L.221, No.63), known as the "Pennsylvania Drug and Alcohol Abuse Control Act."

(b) This section shall not restrict judges of the courts of common pleas, mental health review officers and county mental health and mental retardation administrators from disclosing information to the Pennsylvania State Police or the Pennsylvania State Police from disclosing information to any person, in accordance with the provisions of 18 Pa.C.S. § 6105(c)(4) (relating to persons not to possess, use, manufacture, control, sell or transfer firearms).

Section 112. Rules, Regulations and Forms.--The department shall adopt such rules, regulations and forms as may be required to effectuate the provisions of this act. Rules and regulations adopted under the provisions of this act shall be adopted according to provisions of section 201 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," and the act of July 31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law."

Section 113. Rights and Remedies of Persons in Treatment.--Every person who is in treatment shall be entitled to all other rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in this act. Actions requesting damages, declaratory judgment, injunction, mandamus, writs of prohibition, habeas corpus, including challenges to the legality of detention or degree of restraint, and any other remedies or relief granted by law may be maintained in order to protect and effectuate the rights granted under this act.

Section 114. Immunity from Civil and Criminal Liability.--

(a) In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

(b) A judge or a mental health review officer shall not be civilly or criminally liable for any actions taken or decisions made by him pursuant to the authority conferred by this act.

Section 115. Venue and Location of Legal Proceedings.--

(a) The jurisdiction of the courts of common pleas and juvenile courts conferred by Articles II and III shall be exercised initially by the court for the county in which the subject of the proceedings is or resides. Whenever involuntary treatment is ordered, jurisdiction over any subsequent proceeding shall be retained by the court in which the initial proceedings took place, but may be transferred to the county of the person's usual residence. In all cases, a judge of the court of common pleas or a mental health review officer of the county of venue may conduct legal proceedings at a facility where the person is in treatment whether or not its location is within the county.

(b) Venue for actions instituted to effectuate rights under this act shall be as now or hereafter provided by law.

Section 116. Continuity of Care.--

(a) It shall be the responsibility of the facility administration to refer those voluntary and involuntary patients discharged from State institutional programs to the appropriate county mental health and mental retardation program.

(b) The county mental health and mental retardation program shall, pursuant to Article III of the "Mental Health and Mental Retardation Act of 1966," receive referrals from State-operated facilities and shall be responsible for the treatment needs of county residents discharged from institutions pursuant to Articles II and III of this act.

ARTICLE II

Voluntary Examination and Treatment

Section 201. Persons Who May Authorize Voluntary Treatment.--Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary treatment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

Section 202. To Whom Application May be Made.--Application for voluntary examination and treatment shall be made to an approved facility or to the county administrator, Veterans Administration or other agency of the United States operating a facility for the care and treatment of mental illness. When application is made to the county administrator, he shall designate the approved facility for examination and for such treatment as may be appropriate.

Section 203. Explanation and Consent.--Before a person is accepted for voluntary inpatient treatment, an explanation shall be made to him of such treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject, together with a statement of his rights under this act. Consent shall be given in

writing upon a form adopted by the department. The consent shall include the following representations: That the person understands his treatment will involve inpatient status; that he is willing to be admitted to a designated facility for the purpose of such examination and treatment; and that he consents to such admission voluntarily, without coercion or duress; and, if applicable, that he has voluntarily agreed to remain in treatment for a specified period of no longer than 72 hours after having given written notice of his intent to withdraw from treatment. The consent shall be part of the person's record.

Section 204. Notice to Parents.--Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

Section 205. Physical Examination and Formulation of Individualized Treatment Plan.--Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether inpatient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

Section 206. Withdrawal from Voluntary Inpatient Treatment.--

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203, he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours. Any patient converted from involuntary treatment ordered pursuant to either section 304 or 305 to voluntary treatment status shall agree to remain in treatment for 72 hours after having given written notice of his intent to withdraw from treatment.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may effect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest. The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

Section 207. Transfer of Person in Voluntary Treatment.--A person who is in voluntary treatment may not be transferred from one facility to another without his written consent.

ARTICLE III Involuntary Examination and Treatment

Section 301. Persons Who May be Subject to Involuntary Emergency Examination and Treatment.--

(a) Persons Subject.--Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(b) Determination of Clear and Present Danger.--

(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

(iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation.

Section 302. Involuntary Emergency Examination and Treatment Authorized by a Physician - Not to Exceed One Hundred Twenty Hours.--

(a) Application for Examination.--Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(1) Warrant for Emergency Examination.--Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

(2) Emergency Examination Without a Warrant.--Upon personal observation of the conduct of a person constituting reasonable grounds to believe that he is severely mentally disabled and in need of immediate treatment, any physician or peace officer, or anyone authorized by the county administrator may take such person to an approved facility for an emergency examination. Upon arrival, he shall make a written statement setting forth the grounds for believing the person to be in need of such examination.

(b) Examination and Determination of Need for Emergency Treatment.--A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section 301 and in need of immediate treatment. If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately. If the physician does not so find, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to such place as he may reasonably direct. The physician shall make a record of the examination and his findings. In no event shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application.

(c) Notification of Rights at Emergency Examination.--Upon arrival at the facility, the person shall be informed of the reasons for emergency examination and of his right to communicate immediately with others. He shall be given reasonable use of the telephone. He shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status. The county administrator or the director of the facility shall:

(1) give notice to such parties of the whereabouts and status of the person, how and when he may be contacted and visited, and how they may obtain information concerning him while he is in inpatient treatment; and

(2) take reasonable steps to assure that while the person is detained, the health and safety needs of any of his dependents are met, and that his personal property and the premises he occupies are secure.

(d) Duration of Emergency Examination and Treatment.--A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment and in any event within 120 hours, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202 of this act; or

(2) a certification for extended involuntary emergency treatment is filed pursuant to section 303 of this act.

Section 303. Extended Involuntary Emergency Treatment Certified by a Judge or Mental Health Review Officer - Not to Exceed Twenty Days.--

(a) Persons Subject to Extended Involuntary Emergency Treatment.--Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302 whenever the facility determines that the need for emergency treatment is likely to extend beyond 120 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(b) Appointment of Counsel and Scheduling of Informal Hearing.--Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Conference on Extended Emergency Treatment Application.--

(1) At the commencement of the informal conference, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The judge or mental health review officer may review any relevant information even if it would be normally excluded under rules of evidence if he believes that such information is reliable. The person or his representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person.

(2) A record of the proceedings which need not be a stenographic record shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

(d) Contents of Certification.--A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

(1) findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary;

(2) a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;

(3) any documents required by the provisions of section 302;

(4) the application as filed pursuant to section 303(a);

(5) a statement that the person is represented by counsel; and

(6) an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g), and the continuing right to be represented by counsel.

(e) Filing and Service.--The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c), and on counsel.

(f) Effect of Certification.--Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.--In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment.--Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

- (1) he is admitted to voluntary treatment pursuant to section 202; or
- (2) the court orders involuntary treatment pursuant to section 304.

Section 304. Court-ordered Involuntary Treatment Not to Exceed Ninety Days.--

(a) Persons for Whom Application May be Made.—

(1) A person who is severely mentally disabled and in need of treatment, as defined in section 301(a), may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).

(2) Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

(b) Procedures for Initiating Court-ordered Involuntary Treatment for Persons Already Subject to Involuntary Treatment.--

(1) Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303, 304 and 305 may be made by the county administrator or the director of the facility to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3).

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, his attorney, and those designated to be kept informed, as provided in

section 302(c), including an explanation of the nature of the proceedings, the person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(c) Procedures for Initiating Court-ordered Involuntary Treatment for Persons not in Involuntary Treatment.--

(1) Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment for any person not already in involuntary treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a). The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing a person authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health, and that he may request or be made subject to psychiatric examination under subsection (c)(5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the person shall have the right to have counsel present. A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with section 302 or section 303.

(d) Professional Assistance.--A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings on Petition for Court-ordered Involuntary Treatment.--A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and to the assistance of an expert in mental health.

(2) The person shall not be called as a witness without his consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or his counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(f) Determination and Order.--Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient, or a combination of such treatment as the director of the facility shall from time to time determine. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

(g) Duration of Court-ordered Involuntary Treatment.--

(1) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if the person meets the criteria established by clause (2).

(2) A person may be subject to court-ordered involuntary treatment for a period not to exceed one year if:

(i) severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code: murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (2)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); arson (§ 3301); and

(ii) a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

(3) If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person provided that no person subjected to involuntary treatment pursuant to clause (2) may be discharged without a hearing conducted pursuant to clause (4).

(4) In cases involving involuntary treatment pursuant to clause (2), whenever the period of court-ordered involuntary treatment is about to expire and neither the director nor the county administrator intends to apply for an additional period of court-ordered involuntary treatment pursuant to section 305 or at any time the director concludes that the person is not severely mentally disabled or in need of treatment, the director shall petition the court which ordered the involuntary treatment for the unconditional or conditional release of the person. Notice of such petition shall be given to the person,

the county administrator and the district attorney. Within 15 days after the petition has been filed, the court shall hold a hearing to determine if the person is severely mentally disabled and in need of treatment. Petitions which must be filed simply because the period of involuntary treatment will expire shall be filed at least ten days prior to the expiration of the court-ordered period of involuntary treatment. If the court determines after hearing that the person is severely mentally disabled and in need of treatment, it may order additional involuntary treatment not to exceed one year; if the court does not so determine, it shall order the discharge of the person.

Section 305. Additional Periods of Court-ordered Involuntary Treatment.--

(a) At the expiration of a period of court-ordered involuntary treatment under section 304(g) or this section, the court may order treatment for an additional period upon the application of the county administrator or the director of the facility in which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment. The additional period of involuntary treatment shall not exceed 180 days; provided that persons meeting the criteria of section 304(g)(2) may be subject to an additional period of up to one year of involuntary treatment. A person found dangerous to himself under section 301(b)(2)(i), (ii) or (iii) shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

(b) The director of the facility in which the person is receiving treatment shall notify the county administrator at least ten days prior to the expiration of a period of involuntary commitment ordered under section 304 or this section.

Section 306. Transfer of Persons in Involuntary Treatment.--

(a) Subject to the provisions of subsections (b) and (c), persons in involuntary treatment pursuant to this act may be transferred to any approved facility.

(b) In the absence of an emergency, persons committed pursuant to section 304(g)(2) may not be transferred unless written notice is given to the committing judge and the district attorney in the committing county and no objection is noted from either within 20 days of receipt of said notice. If the court or the district attorney objects to said transfer, a hearing shall be held by the court within 20 days to review the commitment order. A decision shall be rendered within 48 hours after the close of evidence.

(c) Whenever such transfer will constitute a greater restraint, it shall not take place unless, upon hearing, a judge or mental health review officer finds it to be necessary and appropriate.

ARTICLE IV
Determinations Affecting Those Charged With Crime, or Under Sentence

Section 401. Examination and Treatment of a Person Charged with Crime or Serving Sentence.--

(a) Examination and Treatment to be Pursuant to Civil Provisions.--Whenever a person who is charged with crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted for examination and treatment under the civil provisions of this act in the same manner as if he were not so charged or sentenced. Proceedings under this section shall not be initiated for examination and treatment at Veterans Administration facilities if such examination and treatment requires the preparation of competency reports and/or the facility is required to maintain custody and control over the person. Such proceedings, however, shall not affect the conditions of security required by his criminal detention or incarceration.

(b) Status in Voluntary and Involuntary Treatment.--Whenever a person who is detained on criminal charges or is incarcerated is made subject to inpatient examination or treatment, he shall be transferred, for this purpose, to a mental health facility. Transfer may be made to a Veterans Administration facility provided that neither custody nor control are required in addition to examination and treatment. Such individuals transferred to the Veterans Administration are not subject to return by the Federal agency to the authority entitled to have them in custody. During such period, provisions for his security shall continue to be enforced, unless in the interim a pretrial release is effected, or the term of imprisonment expires or is terminated, or it is otherwise ordered by the court having jurisdiction over his criminal status. In those instances where a person is charged with offenses listed in section 304(g)(2) and where the court, after hearing, deems it desirable, security equivalent to the institution to which he is incarcerated must be provided. Upon discharge from treatment, a person who is or remains subject to a detainer or sentence shall be returned to the authority entitled to have him in custody. The period of involuntary treatment shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

(c) Persons Subject to the Juvenile Act.--As to any person who is subject to a petition or who has been committed under the Juvenile Act, the civil provisions of this act applicable to children of his age shall apply to all proceedings for his examination and treatment. If such a person is in detention or is committed, the court having jurisdiction under the Juvenile Act shall determine whether such security conditions shall continue to be enforced during any period of involuntary treatment and to whom the person should be released thereafter.

Section 402. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as Defense.--

(a) Definition of Incompetency.--Whenever a person who has been charged with a crime is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense, he shall be deemed incompetent to be tried, convicted or sentenced so long as such incapacity continues.

(b) Involuntary Treatment of Persons Found Incompetent to Stand Trial Who are Not Mentally Disabled.--Notwithstanding the provisions of Article III of this act, a court may order involuntary treatment of a person found incompetent to stand trial but who is not severely mentally disabled, such involuntary treatment not to exceed a specific period of

60 days. Involuntary treatment pursuant to this subsection may be ordered only if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. The court may order outpatient treatment, partial hospitalization or inpatient treatment.

(c) Application for Incompetency Examination.--Application to the court for an order directing an incompetency examination may be presented by an attorney for the Commonwealth, a person charged with a crime, his counsel, or the warden or other official in charge of the institution or place in which he is detained. A person charged with crime shall be represented either by counsel of his selection or by court-appointed counsel.

(d) Hearing; When Required.--The court, either on application or on its own motion, may order an incompetency examination at any stage in the proceedings and may do so without a hearing unless the examination is objected to by the person charged with a crime or by his counsel. In such event, an examination shall be ordered only after determination upon a hearing that there is a prima facie question of incompetency. Upon completion of the examination, a determination of incompetency shall be made by the court where incompetency is established by a preponderance of the evidence.

(e) Conduct of Examination; Report.--When ordered by the court, an incompetency examination shall take place under the following conditions:

(1) It shall be conducted as an outpatient examination unless an inpatient examination is, or has been, authorized under another provision of this act.

(2) It shall be conducted by at least one psychiatrist or licensed psychologist and may relate both to competency to proceed and to criminal responsibility for the crime charged.

(3) The person shall be entitled to have counsel present with him and shall not be required to answer any questions or to perform tests unless he has moved for or agreed to the examination. Nothing said or done by such person during the examination may be used as evidence against him in any criminal proceedings on any issue other than that of his mental condition.

(4) A report shall be submitted to the court and to counsel and shall contain a description of the examination, which shall include:

(i) diagnosis of the person's mental condition;

(ii) an opinion as to his capacity to understand the nature and object of the criminal proceedings against him and to assist in his defense;

(iii) when so requested, an opinion as to his mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning his mental condition may also be relevant to the question of legal responsibility; and

(iv) when so requested, an opinion as to whether he had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

(f) Experts.--The court may allow a psychiatrist or licensed psychologist retained by the defendant and a psychiatrist or licensed psychologist retained by the Commonwealth to witness and participate in the examination. Whenever a defendant who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist or licensed psychologist, the court shall allow reasonable compensation for the employment of a psychiatrist or licensed psychologist of his selection, which amount shall be chargeable against the mental health and mental retardation program of the locality.

(g) Time Limit on Determination.--The determination of the competency of a person who is detained under a criminal charge shall be rendered by the court within 20 days after the receipt of the report of examination unless the hearing was continued at the person's request.

(h) Definition.--As used in this section, the term "licensed psychologist" means an individual licensed under the act of March 23, 1972 (P.L.136, No.52), known as the "Professional Psychologists Practice Act."

Section 403. Hearing and Determination of Incompetency to Proceed; Stay of Proceedings; Dismissal of Charges.--

(a) Competency Determination and Burden of Proof.--Except for an incompetency examination ordered by the court on its own motion as provided for in section 402(d), the individual making an application to the court for an order directing an incompetency examination shall have the burden of establishing incompetency to proceed by a preponderance of the evidence. The determination shall be made by the court.

(b) Effect as Stay - Exception.--A determination of incompetency to proceed shall effect a stay of the prosecution for so long as such incapacity persists, excepting that any legal objections suitable for determination prior to trial and without the personal participation of the person charged may be raised and decided in the interim.

(c) Defendant's Right to Counsel; Reexamination.--A person who is determined to be incompetent to proceed shall have a continuing right to counsel so long as the criminal charges are pending. Following such determination, the person charged shall be reexamined not less than every 90 days by a psychiatrist appointed by the court and a report of reexamination shall be submitted to the court and to counsel.

(d) Effect on Criminal Detention.--Whenever a person who has been charged with a crime has been determined to be incompetent to proceed, he shall not for that reason alone be denied pretrial release. Nor shall he in any event be detained on the criminal charge longer than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If the court determines there is no such probability, it shall discharge the person. Otherwise, he may continue to be criminally detained so long as such probability exists but in no event longer than the period of time specified in subsection (f).

(e) Resumption of Proceedings or Dismissal.--When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the defendant, determines that such person has regained his competence to proceed, the proceedings shall be resumed. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged.

(f) Stay of Proceedings.--In no instance, except in cases of first and second degree murder, shall the proceedings be stayed for a period in excess of the maximum sentence of confinement that may be imposed for the crime or crimes charged, or ten years, whichever is less. In cases of a charge of first or second degree murder, there shall be no limit on the period during which proceedings may be stayed.

(g) Procedure When Person Is Discharged.--If the person of the defendant is discharged pursuant to subsection (d), but the charges remain open pursuant to subsection (f), the court discharging the defendant shall, on its own motion or on the motion of the Commonwealth or on the motion of the defense, order the defendant to submit to a psychiatric examination every 12 months after said discharge of the person, to determine

whether the defendant has become competent to proceed to trial. If such examination reveals that the defendant has regained competency to proceed, then a hearing shall be scheduled and the court shall determine, after a full and fair hearing, whether the defendant is competent to proceed. If the defendant is adjudged competent, then trial shall commence within 90 days of said adjudication. If such examination reveals that the defendant is incompetent to proceed, the court shall order the defendant to submit to a new competency examination in 12 months.

Section 404. Hearing and Determination of Criminal Responsibility; Bifurcated Trial.--

(a) **Criminal Responsibility Determination by Court.--**At a hearing under section 403 of this act the court may, in its discretion, also hear evidence on whether the person was criminally responsible for the commission of the crime charged. It shall do so in accordance with the rules governing the consideration and determination of the same issue at criminal trial. If the person is found to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, he may raise the defense at such time as he may be tried.

(b) **Opinion Evidence on Mental Condition.--**At a hearing under section 403 or upon trial, a psychiatrist or licensed psychologist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or licensed psychologist or other expert to testify.

(c) **Bifurcation of Issues or Trial.--**Upon trial, the court, in the interest of justice, may direct that the issue of criminal responsibility be heard and determined separately from the other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility and its effect upon other defenses, and the probability of a fair trial.

(d) **Definition.--**As used in this section, the term "licensed psychologist" means an individual licensed under the act of March 23, 1972 (P.L.136, No.52), known as the "Professional Psychologists Practice Act."

Section 405. Examination of Person Charged with Crime as Aid in Sentencing.--Examination Before Imposition of Sentence. Whenever a person who has been criminally charged is to be sentenced, the court may defer sentence and order him to be examined for mental illness to aid it in the determination of disposition. This action may be taken on the court's initiative or on the application of the attorney for the Commonwealth, the person charged, his counsel, or any other person acting in his interest. If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to the civil commitment provisions of Article III.

Section 406. Civil Procedure for Court-ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility or in Conjunction with Sentencing.--Upon a finding of incompetency to stand trial under section 403, after an acquittal by reason of lack of responsibility under section 404, or following an examination in aid of sentencing under section 405, the attorney for the Commonwealth, on his own or acting at the direction of the court, the defendant, his counsel, the county administrator, or any other interested party may petition the same court for an order directing involuntary treatment under section 304.

Section 407. Voluntary Treatment of a Person Charged with Crime or Serving Sentence.—

(a) Whenever a person in criminal detention, whether in lieu of bail or serving a sentence, believes that he is in need of treatment and substantially understands the nature of voluntary treatment he may submit himself to examination and treatment under this act, provided that at least one physician certifies the necessity of such treatment and certifies further that such treatment cannot be adequately provided at the prison or correctional facility where the person then is detained. Such certificate shall set forth the specific grounds which make transfer to a mental health facility necessary. The correctional facility shall secure a written acceptance of the person for inpatient treatment from the mental health facility and shall forward such acceptance to the court.

(b) Before any inmate of a prison or correctional facility may be transferred to a mental health facility for the purpose of examination and treatment the district attorney shall be notified by the correctional facility and shall be given up to 14 days after receipt of notification to conduct an independent examination of the defendant. The court shall review the certification of the physician that such transfer is necessary and the recommendation of the physician for the Commonwealth and may request any other information concerning the necessity of such transfer. Upon the motion of the district attorney, a hearing shall be held on the question of the voluntary treatment of a person charged with a crime or serving a sentence. Upon such review the court shall either approve or disapprove the transfer.

(c) Where possible, the sentencing judge shall preside.

(d) A report of the person's mental condition shall be made by the mental health facility to the court within 30 days of the person's transfer to such facility. Such report shall also set forth the specific grounds which require continued treatment at a mental health facility. After the initial report the facility shall thereafter report to the court every 180 days.

(e) If at any time the person gives notice of his intent to withdraw from treatment at the mental health facility he shall be returned to the authority entitled to have him in custody, or proceedings may be initiated under section 304 of this act. During the pendency of any petition filed under section 304 concerning a person in treatment under this section the mental health facility shall have authority to detain the person regardless of the provisions of section 203, provided that the hearing under section 304 is conducted within seven days of the time the person gives notice of his intent to withdraw from treatment.

(f) The period of voluntary treatment under this section shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

ARTICLE V
Effective Date, Applicability, Repeals and Severability

Section 501. Effective Date and Applicability.--This act shall take effect 60 days after its enactment and shall thereupon apply immediately to all persons receiving voluntary treatment. As to all persons who were made subject to involuntary treatment prior to the effective date, it shall become applicable 180 days thereafter.

Section 502. Repeals.--

(a) The definition of "mental disability" in section 102, and sections 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 416, 418, 419, 420 and 426, act of October 20, 1966 (3rd Sp.Sess., P.L.96, No.6), known as the "Mental Health and Mental Retardation Act of 1966," are hereby repealed, except in so far as they relate to mental retardation or to persons who are mentally retarded.

Section 29 of the act of December 6, 1972 (P.L.1464, No.333), known as the "Juvenile Act," except so far as it relates to mental retardation or to persons who are mentally retarded, is hereby repealed.

(b) All acts and parts of acts are repealed in so far as they are inconsistent herewith.

Section 503. Severability.--If any provision of this act including, but not limited to, any provision relating to children or the application thereof including but not limited to an application thereof to a child is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and to this end the provisions of this act are declared severable.

SOURCE AND DISPOSITION TABLES

Source Table for Proposed Title 50, Part III of the Pennsylvania Consolidated Statutes

Title 50 Pa.C.S.	Mental Health Procedures Act, act of July 9, 1976, P.L. 817, No. 143
§ 3101	§ 101
§ 3102	--
§ 3102 “adequate treatment”	§ 104
§ 3102 “authorized person”	--
§ 3102 “county administrator”	§ 105
§ 3102 “county program”	§ 105
§ 3102 “department”	§ 105
§ 3102 “facility”	§ 103
§ 3102 “incompetence to proceed on criminal charges”	§ 402(a)
§ 3102 “individualized treatment plan”	§ 107
§ 3102 “inpatient treatment”	§ 103
§ 3102 “judge”	--
§ 3102 “licensed clinical psychologist”	55 Pa.Code § 5100.2
§ 3102 “licensed psychologist”	§§ 402(h) and 404(d)
§ 3102 “mental health review officer”	§ 109(a)
§ 3102 “serious mental illness”	--
§ 3102 “severely mentally disabled”	§ 301(a)
§ 3102 “treatment”	§ 104
§ 3103	§ 102
§ 3111	§ 112
§ 3112(a)	§ 112
§ 3112(b)	§ 110(a)
§ 3112(c)	§ 110(b)
§ 3112(d)	§ 110(c)
§ 3113	§ 111(a)
§ 3114(a), (b) and (c)	§ 115(a)
§ 3114 (d)	§ 115(b)
§ 3115	§ 109(a)
§ 3116(a) and (b)	§ 109(d)
§ 3116(c)	§ 111(b)
§ 3121(a)	§102
§ 3121 (b), (c), (d) and (e)	§ 103
§ 3122	§ 116

Title 50 Pa.C.S.	Mental Health Procedures Act, act of July 9, 1976, P.L. 817, No. 143
§ 3123	§ 104
§ 3124	§ 105
§ 3125(a)	§ 106(b) and (c)
§3125(b)	§ 106(b) and (d)
§ 3125(c)	§ 109(c)
§ 3126 (a)	§ 106(a)
§ 3126 (b)	§ 107
§ 3126 (c)	§ 106(d)
§ 3127 (a)	§ 108(a)
§ 3127(b) and (c)	§ 108(b)
§ 3127 (d)	§ 108(c)
§ 3128	--
§ 3131	§ 113
§ 3132(a) and (b)	§ 114(a)
§ 3132(c)	§ 114(b)
§ 3201	§ 201
§ 3202	§ 202
§ 3203	§ 203
§ 3204	§ 204
§ 3205	§ 205
§ 3206(a) and (b)	§ 206(a)
§ 3206 (c) and (d)	§ 206(b)
§ 3206(e)	§ 206(c)
§ 3207	§ 207
§ 3301(a)	§ 301(a)
§ 3301(b)	§ 301(b)(1), first sentence
§ 3301(c)	§301(b)(2)(i)
§ 3301(d)	--
§ 3301(e)	§ 301(b)(2)(ii)
§ 3301(f)	§ 301(b)(2)(iii)
§ 3301(g)	§ 301(b)(1), second and third sentences
§ 3301(h)	§ 301(b)(1), last sentence; 301(b)(2)(ii), last sentence; and 301(b)(2)(iii), last sentence
§ 3302(a)(1)	§ 302(a), first sentence
§3302(a)(2)	§ 302(a), first sentence and 302(a)(1)
§ 3302(a)(3)	§302(a), first sentence and 302(a)(2)
§ 3302(b)	§ 302(b)
§3302(c)(1), (c)(2) and (c)(3)	§ 302(c), introductory language
§ 3302(c)(4)	§ 301(c)(1) and (c)(2)
§ 3302(d)	§ 302(d)
§ 3303(a)	§ 303 (a)
§3303 (b)	§ 303(b), first sentence

Title 50 Pa.C.S.	Mental Health Procedures Act, act of July 9, 1976, P.L. 817, No. 143
§ 3303(c), introductory language	§ 303(b), second sentence
§ 3303(c)(1), (c)(2), (c)(3), (c)(4) and (c)(5)	§ 303(c)(1), first five sentences
§ 3303(c)(6)	§ 303(c)(2)
§ 3303(d)(1)	§ 303(c)(1), last sentence
§ 3303(d)(2)	§ 303(c)(1), penultimate sentence
§ 3303(d)(2)(i)	§ 303(e)
§ 3303(d)(2)(ii)	§ 303(f)
§ 3303(e)	§ 303(d)
§ 3303 (f)	§ 303(h)
§ 3304(a)	§ 304(a)(1)
§ 3304(b)(1), (b)(2), (b)(3), (b)(4) and (b)(5)	§ 304(b)
§ 3304(b)(6)	§ 304(a)(2)
§ 3304(c)	§ 304(c)
§ 3304(d)	§ 304(d)
§ 3304(e)	§ 304(e)
§ 3304(f)	§ 304(f)
§ 3304(g)(1)	§ 304(g)(1)
§ 3304(g)(2)	§ 304(g)(2)
§ 3304(g)(3)	§ 304(g)(3)
§ 3304(h)	§ 304(g)(4)
§ 3305(a), (b), (c) and (d)	§ 305(a)
§ 3305(e)	§ 305(b)
§ 3306	§ 306
§ 3307	§§ 109(b) and 303(g)
§ 3401(a) and (b)	§ 401(a)
§ 3401(c), (d) and (e)	§ 401(b)
§ 3401(f)	§ 401(c)
§ 3402(a)	§ 402(b)
§ 3402(b)	§ 402(c)
§ 3402(c)	§ 402(d)
§ 3402(d)	§ 402(e)
§ 3402(e)	§ 402(f)
§ 3402(f)	§ 402(g)
§ 3403(a)	§§ 402(d) and 403(a)
§ 3403(b), introductory language	§ 402(a) and 403(b)
§ 3403(b)(1)	§ 403(b)
§ 3403(b)(2) and (b)(3)	§ 403(f)
§ 3403(c)	§§ 402(c); 403(c), first sentence
§ 3403(d)	§ 403(c), second sentence
§ 3403(e)	§ 403(d)
§ 3403(f)	§ 403(e)

Title 50 Pa.C.S.	Mental Health Procedures Act, act of July 9, 1976, P.L. 817, No. 143
§ 3403(g)	§ 403(g)
§ 3404	§ 404
§ 3405	§ 405
§ 3406	§ 406
§ 3407(a)	§ 407(a)
§ 3407(b)	§ 407(b), first sentence
§ 3407(c)	§§ 407(b), second sentence and 407(c)
§ 3407(d)	§ 407(b), last sentence
§ 3407(e)	§ 407(d)
§ 3407(f)	§ 407(e)
§ 3407(g)	§ 407(f)

**Disposition Table for
Mental Health Procedures Act**

Mental Health Procedures Act	Purdon's Citation 50 P.S.	50 Pa.C.S. Part III
§ 101	§ 7101	§§ 3101 and 3121(b), (c), (d) and (e)
§ 102	§ 7102	§ 3121(a)
§ 103	§ 7103	§§ 3102 "facility," 3103
§ 104	§ 7104	§§ 3102 "adequate treatment," "inpatient treatment," and "treatment" and 3123
§ 105	§ 7105	§§ 3102 "county administrator," "county program" and "department" and 3124
§ 106(a)	§ 7106	§ 3126(a)
§ 106(b)		§ 3125(a) and (b)
§ 106(c)		§ 3125(a)
§ 106(d)		§§ 3125(b) and 3126(c)
§ 107	§ 7107	§§ 3102 "individualized treatment plan" and 3126(b)
§ 108(a)	§ 7108	§ 3127(a) and (d)
§ 108(b)		§ 3127(b) and (c)
§ 108(c)		§ 3127(d)
§ 109(a)	§ 7109	§§ 3102 "mental health review officer," and 3115
§ 109(b)		§ 3307
§ 109(c)		§ 3125(c)
§ 109(d)		§ 3116(a) and (b)
§ 110(a)	§ 7110	§ 3112(b)
§ 110(b)		§ 3112(c)
§ 110(c)		§ 3112(d)
§ 111(a)	§ 7111	§ 3113
§ 111(b)		§ 3116(c)
§ 112	§ 7112	§§ 3111 and 3112(a)
§ 113	§ 7113	§ 3131
§ 114(a)	§ 7114	§ 3132(a) and (b)
§ 114(b)		§ 3132(c)
§ 115(a)	§ 7115	§ 3114(a), (b) and (c)
§ 115(b)		§ 3114(d)
§ 116	§ 7116	§ 3122
§ 201	§ 7201	§ 3201
§ 202	§ 7202	§ 3202
§ 203	§ 7203	§ 3203
§ 204	§ 7204	§ 3204
§ 205	§ 7205	§ 3205
§ 206(a)	§ 7206	§ 3206(a) and (b)
§ 206(b)		§ 3206(c) and (d)
§ 206(c)		§ 3206(e)

Mental Health Procedures Act	Purdon's Citation 50 P.S.	50 Pa.C.S. Part III
§ 207	§ 7207	§ 3207
§ 301(a)	§ 7301	§§ 3102 "severely mentally disabled" and 3301(a)
§ 301(b)(1), first sentence		§ 3301(b)
§ 301(b)(1), second sentence		§ 3301(g)
§ 301(b)(1), third sentence		§ 3301(g)
§ 301(b)(1), last sentence		§ 3301(h)
§ 301(b)(2)(i)		§ 3301(c)
§ 301(b)(2)(ii)		§ 3301(e)
§ 301(b)(2)(ii), last sentence		§ 3301(h)
§ 301(b)(2)(iii)		§ 3301(f)
§ 301(b)(2)(iii), last sentence		§ 3301(h)
§ 302(a), first sentence	§ 7302	§ 3302(a)(1), (a)(2), and (a)(3)
§ 302(a)(1)		§ 3302(a)(2)
§ 302(a)(2)		§ 3302(a)(3)
§ 302(b)		§ 3302(b)
§ 302(c), introductory language		§ 3302(c)(1), (c)(2) and (c)(3)
§ 302(c)(1)		§ 3302(c)(4)
§ 302(c)(2)		§ 3302(c)(4)
§ 302(d)		§ 3302(d)
§ 303(a)	§ 7303	§ 3303(a)
§ 303(b), first sentence		§ 3303(b)
§ 303(b), second sentence		§ 3303(c), introductory language
§ 303(c)(1), first five sentences		§ 3301(c)(1), (c)(2), (c)(3), (c)(4) and (c)(5)
§ 303(c)(1), last sentence		§ 3301(d)(1)
§ 303(c)(1) penultimate sentence		§ 3301(d)(2)
§ 303(c)(2)		§ 3301(c)(6)
§ 303(d)		§ 3303(e)
§ 303(e)		§ 3303(d)(2)(i)
§ 303(f)		§ 3303(d)(2)(ii)
§ 303(g)		§ 3307
§ 303(h)		§ 3303(f)
§ 304(a)(1)	§ 7304	§ 3304(a)
§ 304(a)(2)		§ 3304(b)(6)
§ 304(b)		§ 3304(b)(1), (b)(2), (b)(3), (b)(4) and (b)(5)
§ 304(c)		§ 3304(c)
§ 304(d)		§ 3304(d)
§ 304(e)		§ 3304(e)
§ 304(f)		§ 3304(f)
§ 304(g)(1)		§ 3304(g)(1)
§ 304(g)(2)		§ 3304(g)(2)
§ 304(g)(3)		§ 3304(g)(3)
§ 304(g)(4)		§ 3304(h)

Mental Health Procedures Act	Purdon's Citation 50 P.S.	50 Pa.C.S. Part III
§ 305(a)	§ 7305	§ 3305(a),(b), (c) and (d)
§ 305(b)		§ 3305(e)
§ 306	§ 7306	§ 3306
§ 401(a)	§ 7401	§ 3401(a) and (b)
§ 401(b)		§ 3401(c), (d) and (e)
§ 401(c)		§ 3104(f)
§ 402(a)	§ 7402	§§ 3102 "incompetence to proceed on criminal charges" 3403(b), introductory language
§ 402(b)		§§ 3402(a) and 3403(c)
§ 402(c)		§ 3402(b)
§ 402(d)		§§ 3402(c) and 3403(a)
§ 402(e)		§ 3402(d)
§ 402(f)		§ 3402(e)
§ 402(g)		§ 3402(f)
§ 402(h)		§ 3102 "licensed psychologist"
§ 403(a)	§ 7403	§ 3403(a)
§ 403(b)		§§ 3403(b), introductory language and § 3403(b)(1)
§ 403(c), first sentence		§ 3403(c)
§ 403(c), second sentence		§ 3403(d)
§ 403(d)		§ 3403(e)
§ 403(e)		§ 3403(f)
§ 403(f)		§ 3403(b)(2) and (b)(3)
§ 403(g)		§ 3403(g)
§ 404(a)	§ 7404	§ 3404(a)
§ 404(b)		§ 3404(b)
§ 404(c)		§ 3404(c)
§ 404(d)		§ 3102 "licensed psychologist"
§ 405	§ 7405	§ 3405
§ 406	§ 7406	§ 3406
§ 407(a)	§ 7407	§ 3407(a)
§ 407(b), first sentence		§ 3407(b)
§ 407(b), second sentence		§ 3407(c)
§ 407(b), last sentence		§ 3407(d)
§ 407(c)		§ 3407(c)
§ 407(d)		§ 3407(e)
§ 407(e)		§ 3407(f)
§ 407(f)		§ 3407(g)

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 226 Session of 2013

INTRODUCED BY CALTAGIRONE, READSHAW, COHEN, SCHLOSSBERG,
FREEMAN, KULA, YOUNGBLOOD, MAHONEY, ROZZI, D. COSTA, WHITE,
V. BROWN, FLECK, CLYMER, GRELL, BISHOP, KORTZ, RAPP, EVERETT,
WATERS, CUTLER, MOLCHANY, DAVIDSON, HENNESSEY AND NEUMAN,
APRIL 9, 2013

REFERRED TO COMMITTEE ON JUDICIARY, APRIL 9, 2013

A RESOLUTION

1 Calling on the Joint State Government Commission to conduct a
2 study of all aspects of Pennsylvania's mental health system
3 and report back with specific recommendations for amendment
4 and improvement, particularly as to how criminal defendants
5 with mental illness are addressed by established procedures,
6 policies and programs.

7 WHEREAS, Mental illness presents a persistent challenge to
8 society in general as it has for centuries; and

9 WHEREAS, The challenge increases when the mentally ill enter
10 the criminal justice system; and

11 WHEREAS, The societal response has often been to segregate
12 the mentally ill from society as a whole; and

13 WHEREAS, The act of July 9, 1976 (P.L.817, No.143), known as
14 the Mental Health Procedures Act, represents a comprehensive and
15 humane governmental response to the issue of mental illness
16 generally; and

17 WHEREAS, The freestanding act has been part of Pennsylvania
18 law for the past 37 years; and

1 WHEREAS, The act and its attendant system are in need of
2 revision and updating; and

3 WHEREAS, In order to determine how to best provide for
4 meaningful amendment to the Mental Health Procedures Act,
5 information on how the present system functions is absolutely
6 necessary; therefore be it

7 RESOLVED, That the House of Representatives call on the Joint
8 State Government Commission to conduct a study of all aspects of
9 Pennsylvania's mental health system and report back with
10 specific recommendations for amendment and improvement,
11 particularly as to how criminal defendants with mental illness
12 are addressed by established procedures, policies and programs;
13 and be it further

14 RESOLVED, That the report is due within one year of the
15 passage of this resolution.