MEMO

DEC 13 2010

Senate of Pennsylvania

December 10, 2010

TO: ALL SENATORS

FROM: Stewart J. Greenleaf Stewart

SUBJECT: Cosponsorship – **Assisted Outpatient Treatment (AOT)**

I am reintroducing **Senate Bill 251**, amending the Mental Health Procedures Act (MHPA) (1976 Act 143). The legislative intent of 1976 was to ensure that persons with the most severe forms of mental illness had a way to get court ordered treatment either in hospitals or in the community. This legislation would provide a way to realize that intent through Assisted Outpatient Treatment (AOT). The legislation is modeled after a New York statute known as "Kendra's Law," but would use only existing community services and programs. As a result, those who are the most ill, but often the least aware of their illness, would not be excluded from receiving services already available in Pennsylvania.

The standard used for commitment under the MHPA is whether the person poses a "clear and present" danger to self or others. Unfortunately, in most cases, by the time an individual with severe and untreated mental illness (i.e., schizophrenia or bipolar disorder) meets this tough standard, inpatient treatment (hospitalization, but even more often, incarceration) is necessitated by the presenting dire circumstances. This legislation slightly modifies the outpatient standard so that persons who are most at risk for homelessness, arrest, incarceration or death due to their mental illness can, in fact, receive treatment in the community. Impaired awareness of illness or anosognosia is the main reason why individuals with severe mental illness do not take their medication and do not recognize their need for treatment.

The purpose of AOT is to provide treatment before harm or violence occurs and without unnecessarily institutionalizing individuals with severe mental illness. While the current law recognizes the need for outpatient treatment, this bill is necessary to provide a framework for AOT so that it can be implemented. The standard for placing an individual in AOT will be easier to meet than the current clear and present danger standard. An individual may be ordered to participate in outpatient treatment if the court finds that there is a history of not complying with treatment and the treatment is necessary to prevent a relapse or deterioration which may result in harm to himself or to others.

Based on "clear and convincing" evidence, the court may order an individual to AOT for an initial period of up to six months. The legislation contains due process requirements and other protections including a petition, hearing, right to counsel, physician's affidavit, and the development of a treatment program. The individualized treatment program may include case management services to provide care coordination, medication, blood tests or urinalysis to determine compliance with prescribed medications. A case manager or treatment team will be designated for each patient. The individual's participation in the program will be monitored. If the individual fails to comply with his treatment program, an evaluation may be ordered to determine whether the individual meets the current clear and present danger standard of the MHPA and inpatient treatment is necessary.

Several evaluations of AOT programs have documented profound findings. The 2005 New York State Assisted Outpatient Treatment Program Evaluation found that during the course of court-ordered treatment, when compared to the three years prior to participation in assisted outpatient treatment, 74% fewer experienced homelessness; 77% fewer experienced psychiatric hospitalization; 83% fewer experienced arrest; 87% fewer experienced incarceration while decreasing victimization and violence and improving compliance to treatment and overall quality of life. The 2009 independent evaluation by the MacArthur Foundation and Duke University, evaluating 10 years of AOT data from New York, reported that AOT "improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients…the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes…the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients…." In addition, perceptions of the AOT Program, experiences of stigma, coercion, and treatment satisfaction were found to be largely unaffected by participation in the program and are likely more strongly shaped by other experiences with mental illness and treatment.

The bill will not require the creation of new services and creates no new programs. Pennsylvania already has programs in the community which individuals with severe mental illness could access if AOT is ordered by a court. Based on New York's experience, it is estimated that Pennsylvania will have a maximum average of 470 people receiving AOT orders each year. Recognizing that the MHPA requires that the least restrictive setting be used to treat the mentally ill, AOT meets that goal and provides a less costly treatment option to involuntary inpatient treatment. Family members should not have to see their loved ones deteriorate to a state of "dangerousness" before they can be allowed to seek treatment.

This legislation is supported by NAMI Pennsylvania (copy attached), NAMI PA Affiliates – Berks, Cambria, Dauphin, Lehigh Valley, Main Line and York, the Pennsylvania Sheriffs' Association, the Newtown Township Police Benevolent Association and the Treatment Advocacy Center. In addition, the bill has received support from several newspapers through editorials from the Philadelphia Inquirer, the Harrisburg Patriot-News, the Daily Review in northern Pennsylvania, the Pocono Record, the Scranton Times and the York Daily Record.

If you would like to cosponsor this legislation, please contact Pat Snively of my office by e-mailing her at psnively@pasen.gov.

Attachment

NAMI-PENNSYLVANIA

Resolution of Support for HB 2186 and SB 251

Founded in 1983, NAMI PA (National Alliance on Mental Illness of Pennsylvania) is the largest statewide non-profit organization dedicated to helping mental health consumers and their families rebuild their lives and conquer the challenges posed by severe and persistent mental illness. This mission is accomplished through programs designed to offer support and education to our membership and to advocate for timely access for better mental health services for them. We also strive to educate the public about the nature of mental illness to combat the stigma and discrimination often faced by persons with mental illness. NAMI PA is composed of consumers of mental health services, families, friends and mental health professionals.

NAMI PA strongly believes that everyone who can make treatment choices should be able to do so. We firmly believe, as family members and professionals, that it is our responsibility to protect the rights of our consumers and family members. We also believe that we can make a difference in the quality of life of our consumers and their families by maximizing positive strengths to seek happiness, opportunities and responsibilities which facilitate their RECOVERY AND RESILIENCY. We seek a balance which recognizes the rights of the consumer, the rights of the family and the rights of the community. This balance recognizes the rights of the consumer to make personal decisions. But it also recognizes the consumer's right to treatment. We know that there are times when persons with severe brain disorders (such as schizophrenia and bipolar disorder) are unable to recognize that they are ill and in need of treatment. We believe that no one should be forced into a situation that requires that they do harm to themselves or others before they are able to get assistance. We also believe that the current standard for involuntary treatment is unevenly interpreted throughout the Commonwealth.

Thirty-four years ago, the Pennsylvania legislature recognized that involuntary psychiatric treatment must be an option when voluntary treatment is not working. This led to the passing of the Mental Health Procedures Act of 1976, which provides a way for people with a severe mental illness to be court-ordered into either inpatient or outpatient treatment.

The problem is with the criteria needed to access outpatient treatment. As it currently stands, the standard for treatment is so high (i.e., a person must have a severe mental illness and be a clear and present danger to self or others) and because the standard is identical for both inpatient and outpatient treatment, it is virtually impossible to realize the legislative intent of providing a way for people who are the most ill to receive treatment outside of a locked hospital setting.

We at NAMI PA know that the least restrictive environment is the most humane and dignified and makes the best use of limited dollars. We believe that modifying the current standard will put additional tools in the community which will enable persons to remain in communities while receiving treatment they need. Consequently, we support passage of HB 2186 and SB 251. By slightly modifying the outpatient standard, people who are the most in need of treatment can receive it in lieu of involuntary hospitalization. It also keeps people out of mental health institutions, jails and prisons. Criminalizing persons with severe mental illness has become an increasing outcome of a system which is inhumane and unacceptable so this very high standard for involuntary access to treatment is much needed.

HB 2186 and SB 251 create no new programs or services. It simply ensures that people with severe mental illnesses have access to the same programs and services which will help them remain in their communities. This is a humane approach that provides support to individuals who need assistance to maintain their dignity and ultimately their independence.

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