COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

HEALTH AND HUMAN SERVICES COMMITTEE

Public Hearing re: House Bill 2186

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Stenographic report of public hearing held at
University of Pennsylvania School of Medicine
Bio-Medical Research Building
421 Curie Boulevard, Room 252
Philadelphia, Pennsylvania
Thursday, April 8, 2010, 11:00 a.m.

HONORABLE Frank L. Oliver, CHAIRMAN
HONORABLE Ronald G. Waters, SUBCOMMITTEE CHAIRMAN

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Reported by: Renée Helmar, Shorthand Reporter

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1420 Walnut Street
Suite 1200
Philadelphia, PA 19103
(215) 928-9760

133 Gaither Drive
Suite H
Mt. Laurel, NJ 08054
(856) 235-5108

I N D E X

(Whereupon, the proceedings commenced at approximately 11:15 a.m.)

MR. CHAIRMAN: Good morning.

The meeting will now come to order.

Thank you very much for being here today for the public hearing pertaining to House Bill 2186.

I am Representative Frank Oliver, Chairman of the Health and Human Services Committee.

I would like members to introduce themselves, personally, if they will, starting from my right.

REPRESENTATIVE CUTLER: Hi. Good morning; Bryan Cutler, Southern Lancaster County 100th District.

REPRESENTATIVE SEIP: Tim Seip, representing part of Schuylkill County and part of Berks County, part of the Yuengling District; I am a licensed social worker and looking forward to the testimony.

Thank you.

MR. CHAIRMAN: Unfortunately, some of the members who are saying they will attend this

hearing today unfortunately haven't arrived as of yet, but, however, we must start this meeting.

So, let us begin.

The first speaker today is Aileen Kroll from the Treatment Advocacy Center.

Miss Kroll, please come forward and begin when you are ready.

MS. KROLL: Thank you.

MR. CHAIRMAN: You may proceed.

MS. KROLL: Thank you.

Good morning, Members of the Committee, and thank you Representative Oliver for convening this public hearing on House Bill 2186. My name is Aileen Kroll, and I am legislative in policy council for the Treatment Advocacy Center, a National Nonprofit Organization with one goal, and that is to eliminate legal barriers to treatment for persons with severe and untreated mental illness.

House Bill 2186 also has one goal, to correct a glitch in Pennsylvania Civil Commitment Code known as the Mental Health

Procedures Act of 1976.

In 1976, the Pennsylvania legislation recognized that there are times when people, by the very nature of their brain disorder, are so ill as to require involuntary treatment either as an inpatient in a hospital setting or in the community.

Receiving this type of community treatment is referred to as assisted outpatient treatment, or AOT.

Assisted outpatient treatment exists in 33 -- 43 states, excuse me, and as of yesterday, Maine has come on board as the 44th.

Because Pennsylvania has AOT for 34 years, I could not understand why I was receiving so many calls from Pennsylvania families desperate for help for their loved ones.

I became involved in this legislation because of the quantity of calls that I received.

I learned that the standard required to receive involuntary mental health treatment in Pennsylvania is clear and present danger to self or others.

In other words, the inpatient and outpatient standards are identical, and with that standard being so high, assisted outpatient treatment is virtually unusable in Pennsylvania.

House Bill 2186 corrects this glitch. It does not change the inpatient standard, but slightly modifies the outpatient standard so that it can be used either in lieu of hospitalization or post hospitalization as a means of ending the cycle of recidivism, in and out of hospitals and jails.

The new criteria for AOT would require a person to be an adult suffering from a mental illness who is unlikely to survive safely in the community with supervision, who has a history of lack of compliance with treatments, that has at least twice within the preceding 36 months been a significant factor in their hospitalization or has resulted in one or more acts, threats or attempts at serious violent behavior toward self or others, and is unlikely to voluntarily participate in the recommended treatment plan, and is in need of assisted

outpatient treatment in order to prevent a relapse or deterioration, which would be likely to pose a clear and present danger of harm to self or others, and it is likely that the person would benefit from AOT.

So, as you can see, the criteria, the new criteria for AOT remains very high, but this slight change from the existing standard would mean that family members and others would have a way to get help for loved ones before they got so ill that the indignities and pain of involuntary inpatient hospitalization were their only recourse.

Recognizing that the current law doesn't work, the former Secretary of the Department of Public Welfare, Estelle Richman, testified before the Pennsylvania Senate in 2007, and stated, "Pennsylvania is in a fortuitous position right now to be able to learn from other states."

Forty-two states currently have some form of involuntary outpatient commitment law.

Several national studies have drawn to a close, and I am directly involved in a number

of these studies.

The most significant analysis underway is a ten-year review by the John D. and Catherine T. McCarthur Foundation comparing the effectiveness of mandated community treatment with non-mandated systems.

The network on mandated community treatment was established to create a scientifically solid basis for developing effective policy and practice on whether and how treatment require certain people with mental disorders to adhere to treatment in the community.

This initiative, now in its eighth year, is very comprehensive in the scope.

And she ends her testimony by saying, I believe it makes the most sense to wait until the evidence is in before we change Pennsylvania law.

I am willing to work with Senator Greenleaf, who was and is the senate sponsor of this legislation, and other co-sponsors to incorporate the results of this research into the legislation.

Well, the good news is that the McCarthur findings were released in June of 2009. They are nothing short of astounding.

Having reviewed ten-years worth of AOT data from New York, the independent research is completed, among other things, that AOT substantially reduces the number of psychiatric hospitalizations and the number of days in the hospital if a person is hospitalized, and reduces the likelihood of being arrested.

They further found that AOT recipients are far more likely to receive psychotropic medications appropriate to their psychiatric conditions and to improve in many areas of personal functioning such as managing appointments, medications and self-care tasks.

Dr. Schwartz and his team also found that in spite of being out of court order, AOT recipients feel neither more positive nor negative about their mental health treatment experiences than people who are not under AOT.

Most compelling to me is, that an AOT is in effect for longer than six months, the improvements are sustainable without requiring

ongoing case management service.

These ten-year findings followed those of New York's Office of Mental Health Five-Year Study.

When compared to 3 years prior, 75 percent of AOT recipients reported that AOT helped them gain control over their lives; 81 percent said that AOT helped them to get and stay well; and 90 percent said that AOT made them more likely to keep appointments and take their medications; 74 percent fewer experienced homelessness; 77 percent fewer experienced psychiatric hospitalizations; 83 percent fewer experienced arrest; and 87 percent fewer experienced incarceration.

In response to these findings, the department issued a draft bulletin.

Since the bulletin is an internal document which is non-binding and has no force of law and does not change the standard, it cannot and does not address the issue before us today.

You may hear today that AOT is a good idea, but Pennsylvania can't afford it. Actually, Pennsylvania can't afford not to

implement AOT.

According to New York's Office of Mental Health, over the course of 11 years, 8379 people were placed on AOT orders, which is approximately 767 people a year across the state.

Adjusting for population, if Pennsylvania implemented AOT as robustly as New York, the projected maximum number of people who would receive AOT across Pennsylvania annually would be 470.

These 470 people are already in the system, but the wrong system, that being the Criminal Justice System.

Let's stop criminalizing people for the crime of mental illness and get them the appropriate treatment, which happens to be, in this case, the most cost-effective approach.

In order to receive AOT under House Bill 2186, an individualized treatment plan is created through the collaborative efforts of the doctor, the subject of the petition and anyone of his or her choosing. That could include family, friends, certified peer

specialists.

The person would have legal representation throughout the proceedings.

Bear in mind that AOT is not a program, and that is why there is no fiscal notes.

House Bill 2186 uses existing community resources.

That means that people who are the most ill will have an opportunity to make use of the services that already exist in Pennsylvania. Pennsylvania is well ahead of most states in this area.

It is number two in per capita spending for mental services. It has 43 ACT and other case enhancement programs along with the commitment to expanding the use of peer specialists.

Because Pennsylvania has invested millions in creating these services and programs, it does not need the infusion of cash that accompanied New York's Kendra's Law.

Bear in mind that New York nor Pennsylvania had these types of services 11 years ago.

The only new addition under House Bill 2186 would be the hiring of program coordinators to ensure that the court orders are being implemented.

Given the small number of people involved, this cost is most nominal, and such a program coordinators may already be employed in the existing case management programs.

Pennsylvania does much right in the realm of medical services, but the people being systematically shut out are those whose illness precludes their awareness of being ill so they cannot voluntarily access the existing services.

While every state wants more mental health programs and services, the small group of people who would be served by AOT are the ones who suffer from anosognosia, which is a lack of awareness of the illness, evidenced by 40 to 60 percent of people with schizophrenia and bipolar disorder.

Absent of court order, no amount of services will make any difference, because there is no awareness of the illness.

This is not denial, it is the manifestation of damage to specific parts of the brain.

As a result, the American Psychiatric Association supports AOT for people with severe and persistent mental illness.

Kendra's Law, the New York AOT Law, over the course of its existence has withstood constitutional scrutiny and legal challenges.

As a result, over the next few years -- excuse me, over the next few months, the New York legislature is not only looking to extend Kendra's Law, but legislation is pending to make it permanent.

Keep in mind that AOT is a mechanism to keep people out of the institutions. It is a way to keep people in their own homes and in their own communities.

And, frankly, given the number of psychiatric hospital beds that are closing, it provides the only mechanism and the only viable option for people short of jail and prisons.

Some will argue that Pennsylvania does not need AOT, but more services.

The McCarthur Study and others find that it is the court order itself that makes the difference in outcome.

The report states, and I quote, "We find that New York State's AOT Program improves a range of important outcomes for its recipients. Apparently without fear of negative consequences to recipients.

The increase services available under AOT clearly improve recipient outcomes.

However, the AOT court order itself and its monitoring will appear to offer additional benefits in improving outcomes.

It is also important to recognize that AOT order exerts a critical effect on the service providers stimulating their efforts to prioritize care for AOT recipients."

In closing, I want to direct you to written testimony of Tanya Feliz, a psychiatric social worker 17 years, and who currently serves as the director of case management at the Family Service Association of Bucks County who is unable to join us today.

Because of her experience of AOT in New

York, we need not hypothesize about whether it would work, her compelling experience has demonstrated the fact that it does through the awesome power of compassionate intervention.

On behalf of Pennsylvania Consumers and families and all who care about wellness and recovery, I thank you for this opportunity, and I ask you to pass House Bill 2186.

I'm certainly available for any questions or comments.

Thank you so much.

(Whereupon, Representative Reichley, Representative Brown and Representative Waters enter the hearing.)

MR. CHAIRMAN: Thank you so much.

Prior to the questions, I would like the members who just finally got here to introduce themselves starting from my far right.

REPRESENTATIVE REICHLEY: Doug Reichley, from the 134th District, Lehigh and Berks County.

REPRESENTATIVE LOWERY BROWN: Vanessa Lowery Brown, from Philadelphia, West

Philadelphia District.

REPRESENTATIVE WATERS: Ron Waters, from West Philadelphia and Delaware County.

MR. CHAIRMAN: Thank you so much.

First of all, I want to say to you that the agenda is very tight, hopefully that we can be as brief as possible as far as questions are concerned.

So, does anybody have a question?

Representative Seip.

REPRESENTATIVE SEIP: Thank you, Mr. Chairman.

I understand the goal of legislation and I, you know, having worked with Bay Service Unit with people suffering from mental illness, I understand sometimes they don't always have a lot of insight into their condition and, you know, even in other realms of our society, whether it is texting while driving or doing a number of things, people don't always do what is probably in their best interest.

In a treatment setting, though, my hesitancy with the bill is, I wonder if we can make people buy into treatment or not? You

know, we can get them in there sometimes, but can we make them open up to treatment? I don't know.

MS. KROLL: Well, I appreciate the question.

I am a firm believer that people should have the right to make all of the mistakes that we have to make and to fall down the rabbit hole as many times as we do. It is all a part of being alive, and there is nothing that any of us can do or should do to prevent it.

That's entirely different from seeing someone suffering from an uncontrollable illness that is treatable so that people are not operating from a place where they are making a decision to not get treatment, they are in an altered state. Because the number of people that we are talking about, this tiny group of people, we're not talking about someone who's ill, we're talking about someone so drastically ill to meet this criteria that they are actively hallucinating. We're talking about people who are not able to care for themselves.

And in those instances, we're talking about intervening so that people do not end up causing tremendous harm to themselves or someone else unwittingly. And this is a way to stay in the community because, right now it is not that if we don't provide AOT people are fine and dandy, without providing AOT people are ending up in the de facto mental institutions. And, as you know, those are jails and prisons.

And I think that we are not doing anyone a favor by saying, we'll just not intervene because we want you to be able to self determine, because in the name of self determination, we are causing people unnecessary pain and suffering.

REPRESENTATIVE SEIP: Okay. I think 1976, was a pretty long time ago --

MS. KROLL: Thirty-four years.

REPRESENTATIVE SEIP: -- to use as a guide for how we proceed now.

One point I do want to make, and I think that we did get away from it is, at least in my experience, that personal contact with

treatment, and I think, you know, a lot of times that we're trying to, whether it be public assistance benefits or mental health treatment, but we're trying to do things over the telephone and we're referring people to the Internet and so forth, and even the unemployment system we've done that.

So, I think a lot of services have gotten away from that personal contact, the relationship building, which is important when we're trying to get somebody to buy into treatment and to trust people that they can work with in the treatment setting.

So, I think that's a part of what we should be looking at is, how much of that personal contact, you know, is it more prudent than having a case manager working with 25 people or so on an intensive level as opposed to somebody who has maybe some telephone or Internet contact with somebody and they have more frequent hospitalizations? I think that's part of the puzzle, too, that we have to look at.

Indifference to the Chairman, I won't take

up anymore time.

MS. KROLL: Let me just quickly respond that, that is why it is extraordinary that Pennsylvania has the number of ACT and ACT-like programs that is the cream of the crop in terms of case management services. And it was developed in Wisconsin.

And in Wisconsin the person who developed it said that there will always be a certain percentage of people in that program who will need to have a court order to get them involved in those services. And in that program, 20 to 25 percent of the people are court ordered.

So, it's not viewed as an aberration, it is viewed as part of the spectrum. And that's what mental health is just like all things if we're looking to add to what is available.

Many things are good, psychiatric advanced directives are good, peer specialists are good, case managers are good. And for a small group of people absent of a court order, they cannot access services.

But I totally agree with you. Personal contact is important, having people being

integrated is important and that's why as it's envisioned in Pennsylvania, it would be individualized treatment plans with people working together to make sure that it is what is working the best.

Thank you.

MR. CHAIRMAN: Any other questions?

Representative Waters.

REPRESENTATIVE WATERS: Yes. Thank you. Thank you, Mr. Chairman.

Thank you, Ms. Kroll.

Ms. Kroll, I heard you mention that the estimated amount of people who are -- probably fell into the cost situation of about four hundred and something you said, that this program would be helpful in preventing incarcerations that are very costly?

MS. KROLL: Yes.

REPRESENTATIVE WATERS: Will people who are coming out of incarceration, because many of the mental problem people who go into the incarceration usually max out because they don't really get better, nothing in the facilities are really there to actually help

treat their problems, and since they max out, now they come out, will they have access to a program, I guess if they had in Pennsylvania, so that when they come out they can get the treatment when they come out?

MS. KROLL: Oh, absolutely. This could be used upon release, and that's how it is done in Los Angeles County, as a matter of fact.

My hope is, that this would be used as a way to enter the system in the first place, because so many people end up being criminalized for behaviors that are secondary to the untreated mental illness, you know.

I'm sure that you'll hear today about mental health courts. These are good things, too, of course, but wouldn't it be better if people got treatments that they wouldn't have to be in that system?

But the short answer to your question is, yes, absolutely.

REPRESENTATIVE WATERS: All right. Thank you.

MR. CHAIRMAN: Are there any other questions?

(Whereupon, there was no response.)

MR. CHAIRMAN: If not, we thank you so much for being here today and making sense of increasing our awareness.

MS. KROLL: Thank you very much, and thank you for having a wonderful staff.

MR. CHAIRMAN: I have always said that I hope that some of my colleagues that are angry about this have always said mine was the best in Harrisburg.

MS. KROLL: Thank you.

MR. CHAIRMAN: Thank you so much.

I just want to say to Representative Waters, I am grateful to him because he brought this to our attention and requested this meeting here today.

So, of course, now, at this time, I'm going to turn the balance of the presentation over to Representative Waters.

You may proceed, sir.

REPRESENTATIVE WATERS: And I thank you, Mr. Chairman, for, as Chairman of the Health and Human Service Committee, for agreeing to

have this hearing here at this time.

So, I want to thank you, University of Pennsylvania, to be our hostess today.

And keeping in line -- I think everybody can hear me.

(Whereupon, Representative Cohen enters the hearing.)

REPRESENTATIVE WATERS: Is that better?

(Whereupon, there was a collective response in the affirmative.)

REPRESENTATIVE WATERS: All right. We want to next ask Melvin Melnick, Dr. Melvin Melnick, please join us for your testimony.

And also entering as another member who has shown up, and is Representative Mark Cohen from East Oak Lane.

REPRESENTATIVE COHEN: Northeast Philadelphia.

REPRESENTATIVE WATERS: Northeast Philadelphia.

You may proceed.

DR. MELNICK: Good morning, Representative Waters, Chairman Oliver, and esteemed Members

of the Committee. Thank you for this opportunity.

I would like to introduce myself, my name is Melvin P. Melnick, M.D.; I am a physician practicing psychiatry in child and adolescent psychiatry in Pittsburgh.

I think of myself coming from Philadelphia and Pittsburgh. I grew up in Philadelphia and attended Hahnemann Medical College, now a part of Drexel University, I went to Pittsburgh for training and was settled there since.

In the course of my career, and incidentally, my career is the same age as the Mental Health Procedures Act, I completed my training in 1976. And over the 34 years, I've maintained a private practice, worked at Community Mental Health, Student Health at Pitt, did hospital work for inpatient child and adolescent unit, worked in residential treatment facilities, and now I'm working for Pressley Ridge, which has a variety of facilities in Pennsylvania.

And I am speaking today on behalf of the Pennsylvania Psychiatric Society, which is

Pennsylvania's branch of the American Psychiatric Association representing over 1700 physicians in the specialty of psychiatry in Pennsylvania. I am also a member of OMHSAS Children's Advisory Committee and chair of the Public Health Subcommittee.

I think there is general agreement, and Attorney Kroll, you used the term glitch, I think there is general agreement that there is some need for change in the system.

And I also think that we have to be extremely respectful of the consumers and families of consumers, and we are extremely sympathetic for the losses that have occurred as a result of the glitches in the system. There is no question that we need to make some changes.

Our concern is that the Mental Health Procedures Act and some changes in its application as a result of court decisions have not been adequately taught and it's there, it is ready to use and it hasn't been used, and I am concerned in practice to start the new with all of the aspects of House Bill 2186 would be

developing an entirely new system that will have its own glitches, as all systems do.

I think that we understand the Mental Health Procedures Act very well. And there's aspects of it which have not been used.

In some ways it was ahead of its time, and as a result of that, it wasn't properly applied. And there are people in Pennsylvania who don't know that assisted outpatient treatment is really available through the Mental Health Procedure Act.

Just to read under Section 304, inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives include consideration of the person's relationship to his community, family, employment and using all community services and guardianship services as well.

In many jurisdictions, because of the uncertainty about how to apply this aspect of the act, it simply isn't used.

So the question then becomes, how do we deal with the glitch and how do we make it

possible to use this aspect? A lot of them has to do with teaching.

I believe that the OMHSAS bulletin, and in practice, standards of care are based on bulletins, standards of care are based on draft bulletins. There is nothing else by way of regulation or standards written elsewhere if what we have is -- even a draft bulletin, that is considered a standard of care.

And in reality, the dangerous task is applied sensibly adhering to the situations, that when it's clear to everybody that without enforced treatment, that there's likely to be a crisis, and somebody is likely to have deterioration to the point of dangerousness and of -- and dangerousness as determined by the Pennsylvania Superior Court, and the Commonwealth Helm's decision includes demonstrating the judgment and understanding so severely impaired that behavior is becoming rational and inappropriate to the situation, preventing someone from getting reasonable nourishment, personal care, medical care or self protection, and making likely that there

would be physical debilitation, including serious bodily injury or death would occur within 30 days unless treatment is provided on an involuntary basis.

Essentially, what I am saying is, that there are aspects of what we need within the current system which we have 34 years of experience with and need to bring up to speed and how it is being applied throughout the state.

And I think that the plan to develop -- to disseminate the bulletin, to do the teaching, there is a training initiative, including a half million dollar from the Pennsylvania Commission on crime and delinquency to develop the training programs for doctors, courts, hospitals and the public to let them know how to use all aspects of the Mental Health Procedures Act.

I've, kind of, given an overview of highlights of the testimony that I have submitted.

I would like to read some things directly from the testimony.

Much of the effectiveness of Kendra's Law, and what is most appealing about House Bill 2186, is the assisted outpatient care teams, with careful evaluation and treatment planning.

It sets up teams which everyone involved knows are needed, but which currently lack funding and accountability.

It is our belief that the same benefits can be accrued to patient care without the creation of additional standards of involuntary commitment by reworking the organization of funding of services of this vulnerable population.

Another appealing aspect of the bill is the concept that we might be able to avoid involuntary patient care by making coerced care available as an outpatient. And as I stated, this is already available through the Mental Health Procedures Act.

A related issue is more troubling. The current Mental Health Procedures Act recognizes that certain behavior merits, confinement or coerced treatment until an underlying illness that is causing the behavior has remitted and

the behavior is unlikely to recur. The focus has always been on actual behavior.

Psychiatrists are certainly very aware of the chronic nature of the illness that we treat.

Our goal must be to help empower consumers to live a full life as possible. But what can constitute a full life must be determined by the autonomy of the person. It is demanded unless there is a very compelling reason to intervene.

We believe that the goals of House Bill 2186 can be met by funded, fully funding assisted outpatient treatment that is already available in Pennsylvania. And treatment that has been developed and guided by the Pennsylvania values of wellness, family participation and recovery, these through advisory boards, through OMHSAS and the spirit of Pennsylvania has been very much developing community-based treatment helping people to use existing resources in the community and to have a recovery-based model with wellness. And there are ways to ensure this.

There are two very important programs in Pennsylvania. One is the Mental Health Advanced Directive, which is a legal document for a person who has some awareness of recurring losses of touch with reality as a result of mental illness and making a determination during a well time about what treatment would be acceptable and what treatment would be unacceptable during a time of exacerbation of symptoms. And there is something comparable that holds less legal status of the wellness recovery application plan which is something similar developed with the treatment team, here are the meds I would take if I'm in a crisis; here are the meds that I would not want to take; this is what I would agree to, I would agree to enforce treatment in order to help me get back to my state of wellness.

I would be remissive if I didn't close by discussing the Duke University Study on New York's assistance outpatient treatment.

In their final summary they noted that the creation of New York's AOT Program was

accompanied by a significant amount of new service dollars, $32 million, plus 125 million in community service dollars, and a development of an entirely new and more comprehensive infrastructure.

The researchers warn that because New York's program is unique, other states may not be as successful to develop the same program in the same way.

The mission of the Pennsylvania Psychiatric Society is to assist those people in the community suffering from mental illness and to assist in providing adequate resources for them to strive in their recovery.

We applaud this Committee for addressing concerns of providing access to outpatient treatment, assisted outpatient treatment.

We look forward to working with you and the Department of Public Welfare in the development of the existing mental health procedure at -- in its useful application to respond to this crisis.

REPRESENTATIVE WATERS: Thank you for your testimony.

Do any Members have any questions?

Representative Seip.

REPRESENTATIVE SEIP: Thanks for your testimony today, Dr. Melnick.

It is interesting that you should mention the 304 Process.

My last day on the job at the Bay Service Unit in Schuylkill County, it was pledged to a commitment day.

DR. MELNICK: To inpatient or outpatient?

REPRESENTATIVE SEIP: Inpatient. Inpatient.

If you could just expound a little bit more on comparing what this legislation proposes and how that would relate to the 304, Section 304, the Mental Health Procedures Act that we already have in place?

DR. MELNICK: Well, I don't know if it's fair for me to be the spokesperson to the usefulness of 2186 because of our concerns about a different emphasis on its application through more of a court system rather than the mental health hearing system and the mental health administration system that we have now.

So, I apologize, but I think that I would not be the best person to do that crosswalk.

Part of, and I think the point that I would like to make is, the programs established through 2186 have their on complexity, and the real proof is in the application, the development of processes that are so complex when they are defined. The proof is in the pudding about the application, how these things would work. We know how the Mental Health Procedures Act works, and we know its shortcomings.

And I think -- my emphasis is, that OMHSAS has a plan to overcome the shortcomings that have made the application of the assisted outpatient treatment not generally well understood and used throughout the city.

REPRESENTATIVE SEIP: If you could just lastly comment on what I said earlier, you have been around a long time, you said that you've been here since the Mental Health Procedures Act was originally implemented back in 1976, do you think that we lost a lot of that human contact that would help avoid or avert some

inpatient stays for consumers?

DR. MELNICK: Well, certainly the initial mental health programs that we're more active in the community.

When I was a medical student at Hahnemann I spent a summer in the Spring Garden area as part of the community mental health team, and I know that when people didn't come for appointments, we went and found them in the community and went into homes and we had that personal contact to say, come with us, it's helped you in the past.

So we were out there and it was really part of what convinced me to go into psychiatry, was to see how much people could be helped when they were engaged in their treatment.

So, yes. I do think there is a change.

I would tell you that during my 11 years working in a hospital setting I did lots of testifying when -- before there was a possibility of parents having a parental consent for the admission of adolescence, that there would have to be a hearing about an

involuntary commitment of adolescence. And there were.

But when the court and the family and the treatment team all were aware of the potential danger of not enforcing treatment, there was pretty appropriate and reasonable application of the standard.

The problem sometimes occurs when the people say, well, everybody knows what's going to happen and everybody knows what's needed.

And I would have to say that we -- that, that is not the case. We are not so clear on being able to predict the future to that degree.

But the concern that this act, that the Mental Health Procedure Act is only used after somebody has done something that is dangerous was not my experience in its application in the hearing room when it was clearly a lifesaving event, even if there wasn't clear cut danger that had already occurred.

When that family and the doctor and the hearing officer knew that treatment needed to be enforced, it was done. And nobody looked up

and said, what does the act say exactly? What people said is, what's going to happen if this person walks out the door? That's the way those hearings went.

REPRESENTATIVE SEIP: Thank you for your response.

REPRESENTATIVE WATERS: Thank you.

Any other Member?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: All right. Thank you so much. We appreciate your testimony.

And we would like to call the next presenter up and that would be Jenna Mehnert.

MS. MEHNERT: Hi.

REPRESENTATIVE WATERS: Welcome to the hearing. And you may begin.

MS. MEHNERT: My name is Jenna Mehnert and I am the executive director of the Pennsylvania Chapter of the National Association of Social Workers.

I am here today to talk about this bill and some concerns that social workers have, but I want to start by saying that social workers

are on both sides of this issue. You'll hear social workers, as you did in the first part of the testimony, in support, and I'm sure that you'll hear social workers later in the afternoon who have some concerns.

I want to lay the framework that, in fact, social work was designated as one of the four core mental health professions in the field -- in the federal legislation that established the National Institute of Mental Health.

The Surgeon General's Report in 1999, identified psychiatric social work as one of the speciality services designated expressly for the services of the delivery of mental health services.

And I also want to highlight that about 60 percent of mental health services in this country are provided by social workers, meaning that we provide more community-based mental health services than any other profession.

So, when you look at this bill, the big issue that pops out, as Representative Seip, who is a social worker, has already expressed, is self-determination. Where do you draw the

line with self-determination?

So, while I'm not going to read my testimony, I wanted to read from our Professional Code of Ethics, which every degree of social worker is obligated to follow, of which there are about 40,000 social workers in the Commonwealth of Pennsylvania, about 11,000 hold a license, and 4000 of them hold a license specifically, an advanced license, as a clinical social worker.

Our Code of Ethics around self-determination states, "Social workers respect and promotes the right of client's self-determination and assist client's in their effort to identify and clarify their goals.

Social workers may limit client's right to self-determination when, in the social worker's professional judgment, client's actions or potential actions pose a serious, foreseeable and eminent risk to themselves or others."

Our Code of Ethics goes on to talk about informed consent where it specifically addresses issues related to this legislation.

In instances when clients are receiving

services involuntarily, social workers should provide information about the nature and extent of those services, and the extent of client's rights to refuse services.

So, while it's very difficult, as I'm sure you all are sitting and thinking about this, to determine whether involuntary commitment in a community-based setting is a good idea, or where you draw the line?

I think that we can all agree that there are cases where you can clearly see that someone is not operating in a way that makes them able to make informed decisions.

But where is that line from someone who, as, you know, might be a bipolar, who enjoys, you know, the up and down of manic depression?

I've known folks who don't want to be medicated because they say when they're manic, they're happier than I'll ever know. And, sure, they will deal with the depression to have that manic stage.

So, how do we decide where that line should be as individuals? When you think about impaired functioning, and I use the example of

driving while under the influence, right, there are laws that we all can't drive under the influence. But there is now laws that we can't be under the influence.

So, how do you think about that context with thinking about mental health treatment and the issues that Representative Seip has already raised about the effectiveness of treatment when an individual is not consenting or engaging in that treatment in a willful manner?

Of course, as the first testifier has already presented, sometimes getting someone in the door and getting them into a state where they can make an informed decision is necessary when someone's brain chemistry doesn't allow them to function in a way that allows them to see the entire scope of their behavior, the options available to them and the decisions that they could make if they were not functioning out of an impaired state.

So, for the social work profession this is a tough issue. We work a lot with families. We provide an incredible amount of talk therapy around the country and here in the Commonwealth

of Pennsylvania to spend a lot of time with clients and their families not only as clinical providers, but as prevention educators, as child welfare workers, as juvenile probation officers, and we see the impacts that untreated individuals have on their families and those actions have on themselves as untreated individuals.

So we can definitely see a need for folks to get treatment, and we definitely have a clear respect for self-determination.

So, as we think about this legislation, it really is one of those balancing acts, where do you draw the line between not being able to drink and drive and not being impaired, and where do we think about ensuring that folks are not in a situation where eminent foreseeable risks to themselves or others is likely to happen? And it is a complicated line and, you know, I am glad that you all are state legislators and not myself.

But I think that thinking about that, but not removing the human aspect, there's lots of family members here today, and I know that you

will hear from the others, from them later, who has been in the situation where they know that if their child, and I actually had a great uncle who was a paranoid schizophrenic who spent his entire life in an institution.

Had he been willing to be medicated, he would have lived with my grandmother, but he wasn't, so he spent, instead, spent his entire life in an institution.

And with all of our values for community-based services, how do you weigh that with the right for self-determination?

So, we wanted to make sure that we're entered into record today, the Social Worker Code of Ethics, since we do deliver such a large majority of talk therapy services.

We also want to raise, too, our concern that the only mental health professional giving any standing in this legislation are doctors and, specifically, psychiatrists, so we would like you all to think about the role specifically of licensed clinical social workers since we do provide an incredible amount of talk therapy in community-based

mental health services, and we are very likely to come in contact with these folks providing talk therapy and realizing that they might need medication.

In fact, we are the folks who refer to psychiatrists to do those kind of evaluations to determine what diagnosis is in place and what medication might be necessary?

But as this legislation is currently drafted, our profession is given no standing in this process. So, clearly that is a concern given our role in the community.

So those are really the concerns that we have and the issues that we debate as we talk about this issue among our profession.

So, clearly I am not here in support or in opposition, but recognizing the need with a lot of concern for how that would be implemented.

Thank you for your time.

REPRESENTATIVE WATERS: Thank you for your testimony.

Before you leave, though, can you answer any questions we might have?

MS. MEHNERT: Of course.

REPRESENTATIVE WATERS: And I appreciate what you have to say about self-determination. We all know how important it is to have self-determination, but we all know there are also many people who had these problems, through no fault of their own, and really be able to make a clear and the right decision, and we know that many people are falling to incarceration and --

MS. MEHNERT: Absolutely.

REPRESENTATIVE WATERS: -- I talked to the Department of Corrections secretary, he said that he believes, I don't know if his is high or low, but he says he thinks about 20 percent of the prison population are people that have mental illness.

MS. MEHNERT: I would say it is higher.

REPRESENTATIVE WATERS: You think it is higher?

MS. MEHNERT: Um-hum.

REPRESENTATIVE WATERS: So, as a result of the fact that we do have people entered into incarceration that shouldn't be there, and definitely not getting the treatment that they

need to correct the problem or treat the problem, self-determination sometimes becomes an issue for legislatures because, even though people can't drink to the point of imparity and drive, I am sure that many people do it anyway, and probably most people get away with it and don't get caught. But every time that it happens and someone causes an accident and someone gets seriously harmed, they ask for tougher laws and they ask for us to do something about it.

MS. MEHNERT: Absolutely.

REPRESENTATIVE WATERS: So, I think that's what we're trying to do right now is, figure out how to strike a balance so that we can do something as lawmakers and try to make things better.

MS. MEHNERT: Well, one of the cornerstones of the social worker profession really is self-determination, but as I said earlier, you know, that that caveat or the kind of line that is drawn for the social worker profession around the client's action or potential actions pose a foreseeable and

eminent risk to themselves or others. That is where we draw the line from saying self-determination should rule to, okay, you know, appropriate intervention now means to compromise that self-determination, you know, when it is eminent foreseeable risk to themselves or to somebody else.

So, I think that, that's not black and white in terms of where that line is, but recognizing as a profession that is built on self-determination, we, too, recognize that there are times when that needs to be compromised.

REPRESENTATIVE WATERS: Thank you.

Any questions from the Members?

Representative Seip.

REPRESENTATIVE SEIP: I'm monopolizing some of the Committee's time here today and I am sorry, Mr. Chairman, but I was going to say, I don't think that there is anybody in the hospital here today that is pro-mental illness, but now that you pointed out the people that enjoy that manic phase, I am going to have to maybe rethink that comment.

But I just want to say that I do appreciate your framing of the issue, and certainly it is important that we have attention to the statement and the worth of the consumers and also their right to self-determine, you know, what they feel is in their best interest if they are capable of doing that.

I am sure as we move along, we'll get additional information and input on this important issue and, hopefully, will lead us to a place that we need to be legislatively.

Thank you.

REPRESENTATIVE WATERS: Any other questions?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: Thank you so much for your testimony.

MS. MEHNERT: Thank you for your time.

REPRESENTATIVE WATERS: I'm going to ask next for, and please forgive me if I pronounce your name incorrectly, and I will do my best, Mary Motolese, Michael Scanlan, Craig DeLarge

and Peggy McGuirk.

I hope that I said your names correctly.

Thank you.

I don't know which order you are going to speak or if you already decided you are going to speak, it is by way which it is listed here. Is that the way that you want to speak, we have Mary speaking first?

MS. McGUIRK: Yes. I'll go first.

REPRESENTATIVE WATERS: All right. Please just identify yourself before you speak. Thank you.

These presenters are from Family Member Advocates.

Since we have four people who want to speak, we are trying to be time conscious as we speak, so, please, if you don't mind, be as direct as possible, make your point. We want to hear your point.

Thank you.

Peggy McGuirk is going to speak first.

MS. McGUIRK: I am here to talk about my son Louie.

When he was little he was probably like

most of your children, he was really cute and very comical. And I may be partial, but I think he grew up to be very handsome, and he is still very comical.

REPRESENTATIVE WATERS: We can't hear you, can you speak up?

MS. McGUIRK: Louie's friends nicknamed him Silly Louie.

When he was in high school he loved the girls, which there was never a shortage of, he loved sports, which he excelled in, and he loved playing guitar and singing. Singing was not so good.

The one thing that I wanted to point out, he was extremely intelligent.

I used to wonder, like a lot of parents do, what he would grow up to be? You know, to me he was the full package.

He had the looks, he had the brains and he had the personality to go with it, and I just thought, he could grow up to be just about anything he wanted to be. The possibilities were endless.

Louie went on to college and that's where

he met his wife, soon-to-be wife, and he has two beautiful children, Zane and Zoe.

Then he decided that he was going to go into the military. He wanted to go into the army and he joined the 82nd Airborne Division. He wanted to be like his uncle, who is in the Delta Force, whom he looked up to and is very -- have great respect for.

He was promoted very quickly because of his intelligence, and he held a high position of high security with a high security clearance.

But after a knee injury and then a surgery and then a reinjury in a parachute jump, his military dreams were ended.

They say if you have an underlying mental illness that hasn't shown up yet, that stress can bring it to the surface. And I believe that's what happened to Louie.

Within a short period of time he lost his military dream, his grandfather, who he is very, very close to became very ill and died, and his marriage was on shaky grounds.

He started acting very bizarre and became

very paranoid. The family was very concerned and we asked for help.

You see, Louie didn't feel that he was acting any differently at all, he thought that we were the ones that were paranoid.

We knew nothing about mental illness only because we had no reason to at that point, but we thought, being a little naive, that we would just tell the doctors what was happening and they would take him to the hospital and they would make him better.

Well, we were shocked when we were told that he would have to become dangerous first before they can help him if he didn't think that he needed help.

I once even begged and pleaded with a particular psychiatrist. I was crying, I was besides myself, and he looked me right in the eye in a very strong tone and he said, your son has a right to be crazy.

Well, I am here today to fight for my son's right to be well.

I had to watch my son lose everything that he had going for him. He lost his wife, his

two children that used to adore him until they became afraid of him, he lost his home, his car, his friends, many jobs and he eventually became homeless.

His ex-wife and I rode all over the place one day looking for him.

I, his mother, I'm sorry to say, or embarrassed to say, drove right past him. I didn't even recognize him. He had lost so much weight, he was filthy dirty, his hair was real long and greasy and straggly, but he had on a shirt that his wife recognized, and that's how we were able to find him.

Well, while we waited for him to become dangerous, I watched him go through periods of delusion.

Once he believed that he was in the CIA and he would speak in some sort of a code.

And then there was another time when he believed he was an army general from the 1800s.

So often during these times he would be taken advantageous of by people that he claimed were his friends. He would become a public nuisance sometimes and I was always worried

that he would end up in jail for it.

Then there was the time I tried to get the whole family together at a restaurant for a special dinner.

And one of the family members suggested to Louie that he needed help.

Well, that time Louie stormed out of the restaurant yelling at the top of his voice to everyone in the restaurant to listen to him because he was Jesus Christ.

The whole family was in tears, but not because we were embarrassed, but because that made everyone know how out of touch with reality Louie really was. He still thought that nothing was wrong with him.

And finally the time did come when Louie was considered dangerous.

You see, still thinking that he was Jesus, he called my daughter and told her that his wife was running a prostitution ring, which was another delusion, and that he would -- she would have to be crucified and that he might have to be the one that does it.

Well, my daughter called us frantic and my

husband and I drove as fast as we could speeding trying to get to our daughter in law, trying to call her over and over and over again, and not being able to reach her, we feared that we were too late.

As it turned out, her phone just wasn't working. So everything did turn out okay, but the story could have ended very differently.

We waited for Louie to finally become dangerous enough to get him the help that he needed, and that could have come at a great cost.

His wife could have been dead. Louie could have ended up in prison or killed by the police and worst off, his kids could have ended up without both parents all because of an outdated law that does not work.

Why should someone have to become dangerous before we step in to help them?

I do believe that people have a right to choose.

If someone has a heart disease and chooses not to get treatment, or if someone with diabetes chooses not to use their insulin,

that's their right. They're making that choice with a clear mind. But when you are asking someone who clearly doesn't understand or realizes they are ill because, it's the brain itself that is ill and not working properly, then that's a very different story.

My son suffered from and still suffers from anosognosia, the lack of insight into his own illness.

I watched him being tortured by his own beliefs about things that he thought were happening to him and to the people he loved, and I still could not convince him that they weren't real. As much as I knew that they were not true, he believed that they were true.

And I told you earlier how I used to wonder when Louie was young what he would grow up to be, but, you know, now, all I want is for him to be safe and as happy as possible.

They say that early treatment can make such a difference in the final outcome of these illnesses.

Well, Louie didn't get that early treatment, he was denied that chance.

So, now, Louie lives with us. He receives social security benefits. He gets to see his children every now and then when I take him to see them in South Carolina, where his wife was originally from and where they live now.

I just feel that this law has ruined the life that my son could have had, not his illness, but this law, it took away his right to be well.

REPRESENTATIVE WATERS: Thank you.

Are you finished?

MS. McGUIRK: Yes.

MS. MOTOLESE: Good morning, Committee Members, my name is Mary Motolese, and I am the proud daughter of Roger and Mary Frances, and the sister of Roger Scanlan.

I am testifying today as a family member who experienced the heart wrenching tragic results of a mentally ill person not getting the right treatment.

As I sit here today, it takes me to the day my family and my life were changed forever.

I can only imagine if a bill like HB 2186 was in place in 2005, how different my life

could be today. My sweet, loving parents might still be here with me. My brother Roger might have had a better, more productive life with the right treatment. Instead, I sit here before you talking about their tragic deaths.

The laws in place when this happened to our family made it difficult as family members to get him placed for treatment.

Our parents, Roger and Mary Frances Scanlan, were murdered on March 19th, 2005, in their home by their son, Roger F. Scanlan, and then Roger took his own life.

Roger suffered from schizoaffective disorder most of his adult life. It began while in the navy, and he continued to fight the disease until his last day.

When he took his medicine, he would be good for a while. Most of the time it was just a short reprieve until the disease would manifest itself again.

Sometimes there were subtle reminders that he was sick, then there were the times when he stopped taking his medicine completely.

In those cases, the outcomes were always

the same, crisis intervention, the police and other mental health workers would need to be called. It was a pattern that would repeat itself over and over again for 25 years, always ending with him being hospitalized for a period of time and then released.

On the day that he killed my parents, he was not taking his medicine. My parents were getting ready to go to my mother's 50th Class Reunion.

And when I was preparing for this, I was looking for things to inspire and to talk about my wonderful parents. And their tickets that they were going to go to the class reunion fell out of the desk, so this is for mom and my dad, this is for you.

They were getting ready to go to my mom's 50th Class Reunion. At the time of their deaths, my parents were still very active in their lives.

However, Roger had begun to take his toll on them.

They started to be afraid to leave him alone, and really had not gone away for awhile.

They always felt they had to protect him, help him and keep him safe.

The class reunion was something they were looking forward to attending. They never made it there.

On March 20th, at 8:30 at night, my life, my family's lives as we knew it forever changed.

I received a call from my Uncle John, my dad's brother, asking if I had talked to my mom and dad? He explained that they had never arrived at the reunion.

I remember that night so well. Things didn't sink in to me right away. It didn't take long until the reality, our worst fears about our brother and what might have happened sunk in.

One of the things we always feared was what happens when he doesn't take his medicine, and none of us can help.

Five long years have gone by and it still makes me cry just thinking about their last moments. There is not a day that goes by that I don't think of them.

They enjoyed their children, their grandchildren and their friends so much. Simply put, they enjoyed life.

They were the most loving and unselfish people I have ever known. They were great parents to all seven of their children. Nothing was too much for them to do for their children.

They never complained to us about the burden placed on them for caring for Roger. They endured many things that we, their children, will never know. They always wanted all of us to live our lives and they would take care of their son, our brother. They really felt their hands were tied when it came to his care.

I will never get over their deaths. Even harder and more painful is the thought of how horrible a death they each died. I miss and love them every day. I have just gone on with my life without them. It is something that doesn't get easier with time.

There are many ways to remember people after they die. Please remember my parents and

brother in this bill, HB 2186, as a reason to change the laws for the mentally ill in Pennsylvania. I am counting on you all to do the right thing. Please do it for Roger J. Scanlan, 71, Mary Frances Scanlan, age 70, and Roger F., age 45. They are worth it and my family loves them.

And I am speaking on behalf of my siblings that aren't here, my sister Kathy, my brother John, my brother Brian, my sister Patty is in the audience, and this (indicating) is my brother Michael.

Thank you for listening, and please think about the possibilities for the ones that we can make a difference.

Thank you.

REPRESENTATIVE WATERS: Thank you, too.

MR. SCANLAN: Excuse me, I took some notes while listening to tweak my testimony here a little bit.

My name is Michael J. Scanlan and this is my personal testimony for public hearing on HB 2186.

October 24th and October 25th, these are

dates that don't have any significance to House Bill 2186. They do, however, have extreme significance to my sisters, Mary and Patty, here today, myself and the rest of our family. You see, October 24th is the birth date of my father, Roger. It is also the birth date of my brother, Roger. He was born on the same day as my father. My mother was born on October 25th.

Never did any of us think they would all die in that manner on the same day. On the same day, March 19th, 2005 -- I thought that I was going to be stronger, but, you know, I am going to do this.

You've heard my sister's testimony, my parents lives were taken by my brother.

He used a knife to kill them and then he cut most of his arteries in his arms and his legs the long way, up and down the legs. I don't know how he could do that to himself. He finally cut his own throat.

I tell you this because I want you to know how tormented and angry he must have been that day.

He was prescribed a drug, it's called

Seroquel. I think the pharmaceutical company named this for the word serene and quell. Also, the generic drug for that is quetiapine, quiet, calm.

Roger was on many drugs over the years for his bipolar disorder and schizophrenia. I always knew when he wasn't taking his meds.

The consequences always took him down the same path. He would become very passionate about government, religion, and then he would believe that he was the second coming of Christ or Moses or some other biblical figure.

We tried to get help for him. We would call crisis. The first question they would always ask was, did he threaten anyone or himself? This was a drill that we went through probably once a month.

You know, he would get on his meds, then he would stop taking his meds; then he would get on his meds and he would stop taking his meds. Then he would drink with it.

Nobody was monitoring anything. I don't know how you could be drinking and taking psych medication and functioning as a normal human

being. Everybody knew this, the doctors knew this.

Their answer to him being Moses was, he could be Moses if he wants to be. He can be Moses if he wants to be.

Now, you're the family member trying to get him help, and I want you to put yourself there for a second, it is a helpless, helpless feeling.

The words to best describe that response was ludicrous or insane, but this -- this was a common, hey, he is not threatening anyone, he is not hurting himself. He can walk around Allentown and be Moses and be dressed like Moses. We could not get him off the street.

How can that be in our society? How can that be? How, in the United States of America, when we are the richest country in the world, are we hanging the mentally ill out to dry like that? I don't get that. I'll never get that. No one will ever be able to tell me that.

My brother had many, many episodes. He had a pattern. Everyone from crisis, the Allentown Police Department, his doctors, they

all knew the pattern. We, as a family, we couldn't intervene to help him. We couldn't get him off the street. We were told that Roger had rights.

What rights did he have to continue to act in such a manner by not taking his meds and what he did, drink with them? What rights did we have? What rights did my mother and father have? They had no choice.

My mother used to say when we would get mad at them, we would get mad because we didn't want to keep harboring his illness and give him a place, we wanted him to hit bottom so that he would get out there and get help. And she'd say, oh, you are all the same. She would get mad at me. She would say, oh, you are all the same.

For years, for 25 years we were dealing with it. For years I'd get -- I never understood it. I never understood why she would say that.

I'd think, well, am I insane? Does she think that I'm crazy? She wasn't saying that at all.

And as a young boy, 16, 17, 18, 19, you don't think -- she was telling me that we were all the same to her. That she loved each and every one of us the same way, and there was nothing that she could do but love him and take care of him because she knew that he wasn't getting any help anywhere else. Not the help that he needed, which was to be cared for almost on a daily basis, or monitored so that he would take his daily meds.

We were told that Roger had rights. What rights did our family have? Apparently none.

The system of treatment for patients like my brother must change.

I wanted to bring my brother's medical records. My brother's medical records from the time that he was -- by the time that he was diagnosed, they were this high (indicating).

That is how much money, and to me I looked at that, I looked at money, money, it must have been a million bucks that was spent on my brother alone. A million dollars. I have to believe that. We spent a lot of money on Roger as a society, as a government. In Pennsylvania

we spent a lot of money.

I was quoted -- I was quoted on the front page of our local newspaper the day after my parents were murdered, I stated that my parents were heros and that they gave their lives for their son. That's exactly what they did.

They were good parents to all seven of their children, and they contributed their time to their community and their church.

My father was president of his church, which is the largest church in Allentown. He was the man. He kept it together. He organized things. He was an organizer.

My brother, Roger, was also a very giving person when he was well. He would have never, ever have taken the lives of his mother and father if he was on his medication and being monitored. He would have never killed them.

I am not angry at my brother. I don't want you to feel that. If you're getting that from me, I am not angry with him. I love my brother.

He would call me at 4:00 in the morning dead drunk telling me that he hated my guts,

and I was there for him. I was his social worker. I was his social worker for 25 years. I got a degree in -- I think that I could have a degree in social work. I always talked him off the fence.

We, as a society, cannot wait until patients like my brother are a danger to themselves or others. We can't wait for that. We can't wait in order for the proper authorities -- we can't wait for them to intervene. Too many instances in this country. And we've seen it. We've seen it. The death tolls are incredible.

Virginia Tech, the parents were afraid of him. Many other instances. I won't name them all.

They could have been avoided if we can step in instead of sitting on our hands and wait for this to happen.

Roger always knew when it was going down. It was going down. It was a five-day pattern. He would feel great, he would stop taking his meds. You knew he was off, and then he would just go down that hill and then he would become

Moses and the police would come. And that was it. The police action in the end.

If much needed regulations were in place in 2005, my parents and brother would be alive today. Instead, the surviving offspring of Mary and Roger, their spouses and children, each day -- we will never forget you mom and dad.

I want to add, and I won't be long, I just had to write some things down.

Listening to you speak today, I know that you have been through the ringer. If you've been dealing with the mentally ill, you've been through the ringer for many, many years I'm sure.

We, as a society, I'm sure, have learned a few things over the years. Thirty-four years is a long time. We, as a society, have improved many things over the years. That's what we do. We see things that need to be tweaked or changed or made better.

Bill 2186 is a way to do that. It is a way to do that. Let's do the right thing here today. Let's do something about this ongoing,

what she (indicating) is going through, what many people that aren't here today are going through.

As far as the human contact, I would just like to touch on that.

We were the human contact. We were his family. We provided support, shelter, food, love, everything that he needed.

So how does this happen? There isn't a way to get professional intervention when someone is not found to be clear and present danger. We never lied. We kept saying no, that he wasn't hurting himself. We never lied. But he needed help to make it better. He wasn't right. He was -- he could have been dead ten years ago.

A guy at one of the halfway houses said, Mike, he said, your family is like a story that you could have had ten different endings, and you got the worst one.

I just wanted to touch, delusions and hallucinations can be dangerous. It can be dangerous.

I always came away after talking with

crisis or anyone, my feelings was that mental illness is a crime. I always felt that.

As a young boy, I thought it was a crime. It must be a crime, the police are always here.

The police were at my home 30 times over the years. There wasn't anybody that come -- none of them were doctors, there wasn't an ambulance out front, there were police cars, 10 of them. It is a crime. I believe that it is a crime. That is why the prisons are full of mentally ill people.

We've taken them out of the hospitals and put them in jail.

I don't know how my brother stayed out of jail, but he stayed out of jail because the cops knew who he was by name, every one of them over the years, by name. Oh, that's Roger, take him to the hospital.

Please, this bill is a way to change things. Get something going. Get something -- add something.

You have no idea. No idea what we go through every day. Every day. It does not get any better. And they are friends.

They had thousands of friends. I am talking, everybody knew them in Allentown.

It wasn't just that my parents died and we are all sad.

He had eight brothers and sisters, my father. Eight. My grandmother had 38 grandchildren. Our family would fill this room and the friends that they had.

It's like -- it was like a bomb going off when this happened in Allentown. It was a bomb going off.

So, if we let one get through the crack, one, that bomb goes off or has a potential to be a nuclear bomb.

And in my parents case, that's what it was. It was a nuclear bomb going off.

I am finished. Thank you for letting me speak here today.

REPRESENTATIVE WATERS: All right. Thank you so much, and we want to go to the last presenter before we open up for any questions.

MR. DeLARGE: My name is Craig DeLarge. Thank you, Members of the Committee.

Representative Cohen, it is great to see

you in person. I've enjoyed our first debates on Facebook.

I will be brief. Though I'm brief, I want to start out by saying that I am not going to go into as much detail, but my situation mirrors very much of what you've heard in the other stories. So let me get to it.

Again, my name is Craig DeLarge; I am a citizen of Philadelphia County.

I am here to testify on behalf of HB 2186, the bill to strength the use of Assisted Outpatient Treatment to improve the quality and even the quantity of life of Pennsylvanians with severe mental illnesses as well as that of their families and caregivers.

I am the father of a young man of 27 years who was diagnosed with schizophrenia at the age of 23. And as far as we know, seemed that he had begun to suffer from these symptoms in his adolescence, but, of course, at that stage in his life we weren't thinking that it was mental illness.

Ours has been a heartbreaking story of repeated hospitalizations, transient

homelessness, social isolation, brushes with the law, and finally imprisonment.

On the other side of that coin is, that there would be many opportunities lost for job training, college education and a productive contribution and, obviously, my wife and I raised our son to mate. Not to mention the fact, and you will appreciate this as legislatures, a lot of tax dollars lost, because he is not as productive as he can be as a citizen, not to mention the fact that the State has put thousands and thousands of dollars into his care in just the last 5 years, and this is a 27-year old young man. So there will be more thousands and thousands if we are not wiser in how we deal with this particular issue.

You know, I'm also, I should add, a board member of the Main Line PA chapter of the National Alliance on Mental Illness, and this has been a way for me to do for others what I've not been able to do for my son, only to his unwillingness to accept a lot of help that has been offered.

And I want you to know, that as a board member, I stand here to let you know that we, as a chapter, have recently signed a resolution which has actually been sent to some of your offices in support of HB 2186 in as much as we believe that it would be a great benefit to the citizens of the Commonwealth.

Taking a retrospective view of the last five years, I cannot help to wonder if my son, at this stage, would have five more years of work experience, a college degree and a nascent career if he had been held more accountable to the mental health system to follow a regimen of treatment and medication.

Unfortunately, as I said earlier, we have a cycle now of ten plus hospitalizations, months and months of transient, hospitalization that is now spread, not just across Pennsylvania, but four other states in our union as we move from state to state, and of course imprisonment in Berks County, Representative Seip, unfortunate to say.

Certainly the time and funding of the government and my family would have been better

invested in setting up a situation of better use in AOT legislation that we have, you know, we would have a much different situation, at least that is my belief.

We are talking about a situation where my son's rejection of help has been not one of deliberate and informed volition, but one of a lack of insight.

We're certainly, in certain episodes when he has had insight, he has gone for help, much to the point that the gentleman here at the end made, we deal with the same cycle, periods of hospitalization where he gets medication, he is then released, he falls apart and the cycle repeats itself.

Unfortunately it has spiraled down to the point where he was in prison.

So, my advocacy for HB 2186 is intended to help citizens like my son who, over time, have demonstrated a lack of ability to maintain their lives owing to a lack of insight into their illness and its relationship to the lack of ability to maintain themselves.

I do not endorse this bill lightly. I can

tell you that our Main Line chapter debated this a long period of time. But, in its -- and I don't take it lightly because, any law has a potential for misuse, but I believe that the benefits in this case outweigh the risk.

And especially given the strident provisions that are in the bill for how it can be used, you know. I read the legislations, I'm sure that you have, there is a pretty high bar of demonstrated lack of insight and lack of ability to maintain one's self that must be demonstrated over time before the provisions that can be enacted.

It is important to recall that we are not asking for new funding or programs, but for an adjustment in the standard reviews to use exist with provisions in our mental health legal framework.

Such an adjustment will result in more citizens of the Commonwealth be helped when they demonstrate that they cannot help themselves.

As a Commonwealth, we show more regard for the physically ill then we're showing for the

mentally ill in this respect.

We can do better for those who are mentally ill and their families, and we should.

Thank you for your consideration of this testimony and for your support in bringing this bill to the Committee. Thank you.

REPRESENTATIVE WATERS: I would like to thank all of you for your testimony, and I am quite sure that I speak for all of the Members of this Committee when I say that we offer our sincere and complete condolences to you and your family.

So thank you for coming here and hearing all of the testimony about what you had went through and your support for this bill. Thank you.

And I would like to turn it over to Chairman Oliver.

MR. CHAIRMAN: Thank you very much.

We just personally had a problem that I was also concerned with, and that was pertaining to the drugs itself.

The thing that bothered me, really, to talk about drugs that the patients use.

In your honest opinion, I am talking about drugs, let's say we consider as very good as opposed to some, in your honest opinion, because of what happened, did you, at any time, think that some drugs that was being taken wasn't the right one or not?

MR. SCANLAN: I got to tell you, that one of the things that my father said to me, you know, was -- my father was a very intelligent man.

He was a Russian linguist in the Air Force. He used to spy on the Russians in Germany. Russian linguist, and he was very, very smart guy. And he would always say to me, he would say, I don't think that Roger matured past the age of 16 or 17 in his mind. This was after 20 years of dealing with his problems.

And one of the things that you hear today is, like, you know, Seroquel is just a drug that -- a lot of these drugs are -- they really don't know what they can do. But I know that they know that they can cause suicidal thoughts in children under the age of 18, and they can write on the television and tell you that,

okay.

Now, a guy like my brother who hasn't matured past the age of 16 years old, does he fit in that category? I mean, it doesn't make sense to me, and I always wondered. I always wondered. I am still wondering, did that drug Seroquel, which was -- he was only on that drug for a month. He was only on that drug for a month.

It was a new drug that -- it is a fairly new drug anyway, but they were trying Seroquel on him. And they didn't find any Seroquel in his system. He was on 1200 milligrams, so he stopped taking his meds for at least four days.

And the day that he killed my parents, he was very agitated. He had one sunglass, one lens in, one lens out.

He was at an AA meeting, and a good friend of ours who would always watch out for him, and he told us after the fact that Roger was agitated that morning. He had a fight with the guy making the coffee and he was just acting very strange.

Well, an hour later he killed my parents.

My dad, he also -- he wanted us to move on with our lives. So he wouldn't tell us when, you know -- as he got older he felt he could handle it.

You want to talk about a martyr, there is my father. He would hide it from us.

But as far as the drugs, personally, they scare me. I mean, they really do these days. These drugs scare me.

I don't know. It is too easy. It is too easy a fix.

MR. CHAIRMAN: Well, see, that's one thing I want to know.

MR. SCANLAN: I mean, you give them a drug and they don't monitor them.

MR. CHAIRMAN: Lyric, as opposed to another one that is supposed to be high quantity --

MS. MOTOLESE: Can I say something?

MR. CHAIRMAN: Yes.

MS. MOTOLESE: My brother's prescription was filled on March 4th, 2005, they died on March 19th. And I say that because he was just put on Seroquel on March 3rd, and no one was

monitoring him. I don't even think my parents knew what kind of drug he was on.

Yet, when I went online after the fact, I was on a mission, I called the Food and Drug Administration and told them what he did on that drug. No one else. I did. And -- or lack of that drug.

But my point is, they put them on the medicine, the doctors, and they just let him out and they don't monitor it.

And this kind of legislation could help protect people like my mom or dad, protect my brother, her son. These things shouldn't happen. They are like ticking time bombs, and -- to anyone, not just their family.

So I just wanted to bring that to your attention.

MR. CHAIRMAN: Thank you very much.

MR. SCANLAN: We are not trying to change the 1970s legislature, but I just think that we have to had learned something. We got new meds out there. We've had to have learned something since 1976.

I know one thing, they are closing all the

state hospitals. They're closing them. A lot of people might think that's a good thing, but where do the really sick people go? I mean, the really sick people that can't take care of themselves, the delusional, where do they go? They're going to jail. Eventually they're going to go to jail or someone is going to kill them.

My brother was very giving, I told you that. He gave away almost all of his money.

When he left the navy he had $10,000.

The United States Navy put him on a bus, and needless to say, he's right here (indicating), a good looking kid, put him on a bus and totally, a complete nervous breakdown.

He had more LSD in his system that could have killed a horse.

Did they treat him? Basically, they got him to a level where he could probably walk, and then they put him on a bus and sent him on his way. Honorable discharge. Ten thousand bucks, see you later.

He was dancing with some guy's girlfriend in Tijuana. That's the last thing that he

remembers. He came back, drank his drink and that was it.

The drugs, I don't know. I really don't.

MR. CHAIRMAN: Thank you.

MS. McGUIRK: Can I say something about the drugs?

One drug could be bad for somebody and have a bad reaction, but it might be a lifesaver for somebody else, you know.

It is, kind of, like a needle in a haystack, you have to find the right drug for you, you know. But you'd have to have them monitored, that's the whole thing.

Somebody has to be watching to see what's going on. Somebody that knows what they are doing, not family members. We don't know, you know.

We can get on the computer and look up the drugs and see what they say to watch for. That really is not our job. But it is being left to us.

And I just wanted to say one or two other things real quick.

I think social workers are great. I think

that they do a wonderful job. I think all the different services that are out there that we have, you know, are wonderful, but you can't get somebody to engage in them and they may as well not even be there for those people, because you can't get them to go because they don't think they are ill. It takes something extra, this little push to get them to go get the services.

My son was in and out of the hospital five times in one year, and then ended up going and spending four to five months in a state hospital.

I mean, there is so much money being wasted. I mean, we have to look at preventative medicine, you know. Give them the help first, you know. Don't wait until they are so bad that they become dangerous. We want to clean up the law that we have now.

But it still comes down to the fact that they have to be dangerous before, no matter how much you clean it up, you still have to be dangerous first before you can use it. You know, that just doesn't make any sense.

MR. SCANLAN: I always thought -- I always wonder this, and we were talking the other day about it, I'll talk about it, when you see a pattern, continual pattern over the years, this guy is a risk, this is his deal.

I mean, we have a three strikes you're out laws, we have drunk driving laws, we have all these, you know, discoveries and changes in laws over the years to make things tougher.

Well, in my brother's case, if somebody, I believe, made him comply -- he was taken off the street 30 times, police force, they all know you, you are a habitual offender. You are not taking care of yourself. We are giving you all the means to take care of yourself, but you are not doing it over here.

And what's happening is they are getting thrown in jail. Over 60 percent, they are in jail.

So we got to do something for them over here. You got to help them over here on this side.

And if it means spending some money, then we got to spend the money, because we can't

have people killing people.

MS. McGUIRK: One thing about the prison system, I just want to mention that my daughter's girlfriend's husband works at a prison in our area and he had to work overtime two weeks ago because he had to do inventory because of three busloads of prisoners were sent from Pennsylvania to Michigan because our prisons are all full.

I mean, they are closing the mental hospitals and they are building more prisons and sending them out of state until they can build them.

I mean, it's -- something is really wrong here.

REPRESENTATIVE WATERS: I absolutely agree, and it is a concern that we share with you. We got to fix the problem before, rather than just treat the problem. We got to stop it. We do.

I want to ask State Representative Mark Cohen.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

I would like to focus on, I'm very moved by your testimony, I'd like to focus on the criteria for assisted outpatient treatment to this bill and the criteria B4, Sections 1 and 2 basically lists three different reasons why somebody would be subject to this bill.

And I would just like to ask to what degree your particular situations were affected by these criteria?

Now, I think the first criteria is at least twice preceding the 36 months, the mental illness has been a significant factor in necessitating hospitalization.

I assume everybody here, from your testimony, is going through that; okay.

And the second criteria is receipt of services in a forensic or other mental health unit or correctional facility.

Did any of you go through that one?

MR. SCANLAN: Yes.

REPRESENTATIVE COHEN: Okay. And the third one is one or more acts of serious violent behavior to self or others or attempted serious physical harm to self or others in the

preceding 48 months.

Did you have that?

MS. MOTOLESE: Yes.

REPRESENTATIVE COHEN: All of that, too?

MR. SCANLAN: Um-hum.

REPRESENTATIVE COHEN: Okay. Thank you very much. Thank you again for your testimony.

REPRESENTATIVE WATERS: Thank you.

Representative Reichley.

REPRESENTATIVE REICHLEY: Thank you, Mr. Chairman; thank you, Representative Waters.

I just wanted to make a quick comment and I have to get out to Harrisburg, unfortunately, right now.

But I wanted to join the other members in expressing our thanks for your very heartfelt testimony.

I have a little bit of a relationship with your situation, that my district covers an area, Lower Macungie, where a young man just about three years ago killed his father and he is now in state prison on a murder three sentence.

They called crisis intervention. Crisis

said, you know, he is not a danger or a threat or he is not a danger to himself or others.

And then about an hour later he had taken his father's life and --

MR. SCANLAN: I know that story very well.

REPRESENTATIVE REICHLEY: Yeah.

MR. SCANLAN: John McQue.

REPRESENTATIVE REICHLEY: John McQue, yes.

MR. SCANLAN: He has a sister; right?

REPRESENTATIVE REICHLEY: Yeah. Right.

MR. SCANLAN: His son.

REPRESENTATIVE REICHLEY: Yeah.

So -- and I prosecuted people, another young man actually in Lower Macungie who killed his parents and is now in Norristown as a not guilty by reason of insanity. So this is a pervasive problem.

I guess my only comment, that while I recognize the professionals and the providers here in the audience, Dr. Melnick and Miss Mehnert who may not still be here, has some substitutive objections to the language of the bill.

I would just encourage everybody to try

and work together to resolve this issue.

I guess it could have to take a lawsuit being filed against maybe crisis intervention or county or the provider or the drug company to say that you are all negligent in not addressing this person's concerns, but I don't think that we want to go down that route and that may not be productive, but it's going to be a very expensive route as well.

But the cost that it is having on our society by not adequately treating mental illness, I think, is going to have a much more devastating effect, sort of the unmentioned fact in this current debate about healthcare that we're having right now around the country about insufficient contact.

So, I would encourage both the advocates for the individual recipients, family members, the professionals, to all, sort of, drop their steadfast objections to one kind of language or another and try to work to resolve this.

Thank you, Mr. Chairman.

Thank you.

REPRESENTATIVE WATERS: Thank you,

Representative.

Anymore questions?

Representative Seip.

REPRESENTATIVE SEIP: Thank you, Mr. Chairman.

I appreciate and value all of your comments. That has been very helpful and insightful for the Members of the Committee.

One of the things that came to mind as you were giving your testimony is the fact that we have that threshold, that act of furtherance, do they have a plan? What is the next step? What do you think they might be capable of? What's the next -- well, you know, they haven't made any threats, they, you know -- and then the criteria of that threshold isn't met.

Maybe we need to look at this as an issue of being incapacitated. You know, is the consumer incapacitated? Are they unable to make decisions that aren't in the best interest --

MR. SCANLAN: There is commonsense, I feel.

Put yourself right here, your brother is

Moses. You got to get him help. You got to get him into something. He's got to stop being Moses, he's got to be Roger.

REPRESENTATIVE SEIP: And the other point that I want to make, sometimes, you know, when somebody is impaired or suffering from mental illness and they feel like they're being forced into something, then their mindset is to fight off those overt threats to them or perceived overt threats to them and their autonomy. And they put a lot of energy into that as opposed to their treatment and maintain their medication regiments and stuff like that.

So I really appreciate your passion and your insight.

And, again, I hope that we're able to, as a committee, tackle this issue and move the Commonwealth in the correct direction.

MS. McGUIRK: Can I respond to that?

MR. CHAIRMAN: Sure.

MS. McGUIRK: My son resisted all attempts to get him treatment because there was nothing wrong with him.

Today, he supports this bill.

He wishes so much that somebody would have stepped in sooner, did something sooner before he lost everything that he had.

Now, at that time, he didn't want the help because his mind wasn't working clearly.

We were asking him to make decisions and choices when he didn't have a clear mind. You know, that is the difference here. That is the whole difference here. They just don't get it.

MR. CHAIRMAN: You are right.

MS. McGUIRK: And anosognosia is an actual illness.

I mean, you can read about it. The brain is impaired. They can't see the reality.

REPRESENTATIVE SEIP: Thank you. Thank you for your comments.

Thank you, Mr. Chairman.

REPRESENTATIVE WATERS: Thank you, too.

We have to move along. Thank you all for coming here.

As I said earlier, your testimony won't be lost. We're hoping to get this right.

MR. SCANLAN: This hearing is a good healing process for it, and we thank you for

letting us do this, because it is going to help us heal.

That is one of the benefits to sit here and to talk to you gentlemen here today, and ladies.

REPRESENTATIVE WATERS: We are going to have another hearing on this issue in Harrisburg, so...

MR. SCANLAN: I would like to be there.

REPRESENTATIVE WATERS: We will make sure that everyone is informed about the next hearing that we have.

MR. SCANLAN: Thank you.

REPRESENTATIVE WATERS: Thank you very much.

Okay. We would like to ask Robert Meek, Esquire, join us.

And I don't know if you have written testimony, but for the remainder of the --

MR. MEEK: I will be happy to be brief.

REPRESENTATIVE WATERS: Thank you.

MR. MEEK: And I wanted to -- I have written remarks and the Committee has already seen them and I really appreciate the

opportunity to speak with you briefly.

And thank you very much, Chairman Oliver, and, Representative Waters, and the rest of the Committee.

Just so I will give the preliminary stuff over with, my name is Robert Meek, and I am an attorney with the Disability Rights Network of Pennsylvania, which is the organization that has been designated by the Commonwealth pursuant to federal law to advocate for and protect the rights of individuals with mental illness.

I have been in this position for 20 years and largely focused on trying to secure appropriate community-based treatment for individuals with mental illness. I also sit on the Pennsylvania Commission on Crime and Delinquency Advisory and Mental Health Advisory Task Force, which has obviously some role to play with regard to some of the illness that have been mentioned today, but especially in regard to the Criminal Justice System when people with mental illness run afoul of the law.

I want to start out by saying I am completely empathizing, I understand the plight of the family members that are expressed today and it is very, very heartfelt way, and I certainly appreciate their comments and I actually agree with everything that they said because, I think that what happened to them was, the system failed them. And that's the problem, that we have a system that could address the problems that were raised by their family members.

Unfortunately, the players in the system that are supposed to do that didn't do what they were supposed to do.

And, Representative, I think your idea is really a good one regarding the incapacity to care for one's self is where the care -- the provider should look instead of the dangerousness provision, because dangerous, let's face it, is a very, very tricky thing, especially because, as I think Dr. Melnick mentioned, I thought, very clickingly, that dangerousness is impossible to predict practically impossible to predict. Certain

behavior patterns will emerge, as everyone has testified today, but I think the problem is that you can't predict dangerousness. And that's what makes dangerous rather hard to apply in a meaningful way.

I know that, and you could probably hear about this, but depending on where you are and where you go to seek services, some places you are going to find that, you know, jaywalking is going to be considered dangerous, whereas in other jurisdictions, you know, may not be considered dangerous.

So, it is a real problem with application standards, number one, of the current standards, which, I argue, we have in place, as Dr. Melnick, I thought, put very well, that the standards exist are appropriate, they could be utilized, but just haven't been utilized.

The bulletin, the draft bulletin that the department has issued helps clarify that. Obviously, that was in response to this bill and we recognize that, but I think that if applied appropriately, some education amongst crisis intervention teams to appropriately

access the situation of people and not to say, well, if he is not a danger to himself or others within the last 30 days, then I'm not going to talk to you.

And that is, unfortunately, often done because of the economic motives. It cost money for them to treat people and they have limited resources.

So, really, the problem is, how do we apply the current standards in a way that actually is going to address, and I think would have addressed properly by all the problems that we've heard about today where family members have suffered greatly, grievously as persons with mental illness without impinging on fairly, solidly recognized constitutional rights that have been fought for and that are well established in the law?

I think it is a very difficult balancing act all and close to my immediate, and in some senses the criminal context where the law has been established to protect the innocent, unfortunately as well as the guilty, because the philosophy is, that it is better that, you

heard this, it is better that 99 people guilty go free then one innocent man is convicted.

Now, that's easy for me to say because I'm not the victim of the 99 people committing crimes. But the philosophy is there that the Constitution is there to protect peoples rights against government intrusion.

And this is a government intrusion. We enforce psychiatric medications on someone against their will, that's intrusion by the government, because the government is giving the authority of the person administering that through the law to do so against your will.

So, the State has to have justification to give that authority to other so-called parents that have the authority or the state police power of authority to intervene in someone's life in a very, very intrusive way to prevent greater harm, that's the notion.

So, again, it is a very difficult balancing act, we know that.

And, again, I think that Dr. Melnick mentioned this as well, I'm not trying to echo everything that Dr. Melnick said, but what he

said made a lot of sense, that we need to really look at educating our system in a better way to recognize what is appropriate, what's an appropriate point of intervention without violating the rights of individuals?

And I think that you hit a cord that it makes sense. If someone is walking around the street saying or addressing they are Moses or they're completely destitute and living on the street, I think it is not a stretch to say that, that person is probably not capable of taking care of himself. And that would be some of the criteria by which they could get committed.

However, the problem is, also, there are many, many well meaning and certainly caring family members, but sometimes -- occasionally somebody's family is not their best friend and they are often not -- the laws can be abused to intrude on a person's privacy in life in a way that is inappropriate.

So, while that is not what we are here about today, but does occur.

In fact, we're trying to get a law passed

called, Adult Protective Services, to protect people from what usually is a family member abusing them and using the law against them.

So, again, there is two sides to every story, and I certainly understand the family members side as well.

I've dealt with many family members as well as many individuals with mental illness, and they do, indeed -- there is probably no one enjoying mental illness, as we say.

But, again, we have to be mindful that there is some -- some leeway must be given for advert behavior, certainly.

When it becomes dangerous to the person, and I think inability to care for one's self in a meaningful way is one of those, that may be the kind of route using the current law that might be more appropriate or should be used more.

I am not a promoter of involuntary commitment, outpatient idolize, but certainly it is necessary in some occasions. We don't disagree with that.

Our concern is simply to limit it to those

persons who truly need it and certainly to prevent tragedies of such as the ones that we heard about today. No one wants those things to occur clearly. And if we could have a magic wand to prevent those things from happening, I would be happy to use it.

I think that we have some tools that need to be appropriately utilized and, unfortunately, I think that the bill is not a panacea, it loosens up the language about likelihood, which I think we're trying to predict future dangerousness, which I think anyone will tell you, is a difficult task, indeed.

So we think there is some Constitutional flaws to the bill that will have problems passing muster.

So -- but what we would argue is, that the current law is something that can be utilized in a more effective way. We talk heartfelt, take this step in the right direction. And it is hard to clarify the use of the current law, and I think that we could educate both families and providers of emergency services and other

services to look more carefully at preventing tragedy and using the law in a way that can do that.

I agree that one of the things that is sorely lacking is continued intervention in a person's life in a non-intrusive way, monitoring medications, having people see psychiatrists and psychologists on a much more regular basis then they are able to now.

If you go to your BSU and you can get an appointment with your psychologist or psychiatrist more than once a month, you are a lucky person, because it just happens because they don't have the resources to give. And that is because the money is not going up, it is going down in mental health.

And there is a huge array, Philadelphia is a great example, a huge array of kinds of services, and every kind of innovative service that is possible in mental health, I think, exists in some form in Philadelphia and many other counties.

The problem is, there is just not enough of them. They exist, but there is not enough

to treat all of the people that need that treatment and that kind of intervention.

Another thing that I wanted to mention is, that what this bill doesn't do is address one of the more -- the entire need of housing and stability for people with mental illness.

There are many studies out there, especially in New York, the Housing First, Corporation, that will tell you that housing is the lynchpin to stability for people with mental illness.

And with appropriate housing, people realize that they can get help and will get help.

Now, there is always going to be resistors.

And, in fact, the bill, itself, HB 2186, contemplates that some people will not comply with the court order. Of course we know that.

There are plenty of people that, you know. there is always going to be a percentage of people who are not going to comply.

So the result is, they end up, sort of, back in the old system anyway. They get

committed anyway.

I think what we need to do, and what we heard otherwise, is instead of using outpatient commitment, end of the psychiatric hospitalization, it should be the first look, is let's think about, can we do an outpatient prior to necessity for inpatient, and then see if that moves the person in the right direction before the treatment.

Again, I cohort the literature in a professional coercive treatment tends not to work. It runs contrary to the whole notion of the recovery.

The recovery is a self-initiated, sort of, thing that we can't make someone want to recover. They, sort of, have to get it themselves.

And we agree that getting someone in the door has some short term beneficial affect, but doesn't keep them, as the old saying goes, you can lead a horse to water, but you can't make them drink. You might be able to get them to drink once, but not get them to drink on a sustained basis. And that's really what we're

talking about here, is a continuous monitoring and continuous support.

And think of it more as a support around a person, builds around a person so they remain stable so they want to continue in treatment.

And for those small number of people who cannot or will not cope with the voluntary thing, then there is the outpatient -- I'm sorry, the inpatient route.

But -- and this bill also calls for that. So I'm not sure there is no added value that the bill provides for the treatment in that scheme in Pennsylvania in order to appropriately use our current system will do the trick.

I am happy to take any questions.

REPRESENTATIVE WATERS: Thank you for your testimony and thank you for your offer to answer any questions.

Representative Cohen.

REPRESENTATIVE COHEN: Thank you.

This bill changes the standard. You say that, that is not necessary. And I am sure there are all sorts of legal precedence

interpreting the current standard.

MR. MEEK: There are indeed. And the current standard is both U.S. Supreme Court and Pennsylvania Supreme Court have indicated, that in order for the State to take -- to impose its will on a person in order to violate their liberty by integrity and otherwise, there must be a significant justification in doing so.

And what that standard has come down to be is called a clear and present danger standard, and that was codified in our procedures act as the Overt Act within the last 30 days based on mental illness.

And, also, a lesser thing for parents, they have the authority of the State to take care of persons who cannot take care of themselves. And that is the other part of the statute that is rarely talked about.

Representative Seip mentioned as one that's been, sort of, lost in the woodwork and might be a more appropriate way of addressing these sort of problems.

But the standards have been constitutionally challenged in other contexts,

but in both the clear and present danger aspect and also enforced medication round where the Court of Appeals ruled in Rain versus Kleinbach in 1983, that there is a certain process you have to go through for forced medication in a non-emergency situation. In an emergency situation that is different and it is an easier -- it is a lower standard.

REPRESENTATIVE COHEN: Well, I guess the advocates here would like the courts to revisit this. And the way to get the courts to revisit it is to create a new standard that has to be interpreted by the courts.

MR. MEEK: Right. That is certainly likely or possible that if a new statute were passed and it was challenged on constitutional grounds, then it would give an opportunity to the court to change its view on the clear and present danger standards. Absolutely.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

REPRESENTATIVE WATERS: Thank you.

Any other questions for Mr. Meek?

(Whereupon, there was no

response.)

REPRESENTATIVE WATERS: All right. Seeing none --

MR. MEEK: Thank you very much.

REPRESENTATIVE WATERS: -- I thank Mr. Meek for coming here.

The next presenter is Wendy Stewart, Executive Director, NAMI, Cambria County and Curt Bauer, Consumer.

Thank you. And as I have already stated prior to your coming here, if we could kindly speed this up a little bit so that we will be out here in the time that we are supposed to be out of here.

Thank you, and you may begin.

MS. STEWART: I would be happy to defer to Curt. He is somebody who has a very personal story to share from a consumer perspective, and if you want to have your time spent listening to anyone, I would like him to go first, if that's all right?

REPRESENTATIVE WATERS: That is fine.

MR. BAUER: Good afternoon. Let me start by expressing my gratitude to the Committee for

allowing me to testimony for the passage of House Bill 2186.

If, in the not too distant past, things did not change, I would not be here to testify before this Committee.

I was born in the western part of the state, the middle child, with an older brother and a younger sister. We were raised in a strong Catholic tradition, and a blue collar work ethic. Our mother was emotionally distant, and our father was the nurturing caregiver.

During my childhood and adolescence I had many acquaintances, but very few friends. Moodiness was the excuse given by my friends when I wondered why people seemed so distant and remote throughout my preteen and teenage years. Classmates were not sure which Curt they were going to associate with. Some days I'd be outgoing, friendly and caring, while at other times I would be detached, isolated and indifferent.

The pattern continued to challenge my life for a very long time. It is explained, I

believe, by my family dynamics.

I learned to be emotionally distant, guarded and critical through my mother, while learning to care, nurture and love through my father. This emotional paradox is present throughout my life and history and I'm on guard to recognize it even in my recovery.

Upon high school graduation, I attended a very prominent Catholic university. I received a Bachelor of Arts Degree in Philosophy with a heavy emphasis on Theology and Psychology.

Upon graduation and recently married with one son, I went to graduate school and attained a Master of Arts Degree in Psychology.

The only reason I mention this is because of insidiousness nature of mental illness.

One would think that with an advanced degree in Psychology, it would be natural to see and recognize a psychological illness in one self. Not true.

In graduate school, I also attained a certificate to become a Respiratory Care Practitioner.

Respiratory therapists are concerned with

the heart and lungs.

My duties included care for ventilator patients, breathing treatments, instruction, CPR and a host of other procedures related to the care of heart and lungs.

Respiratory care became my profession for the next 25 to 30 years providing for our family, which numbered four after the birth of our second son.

The professional life I chose proved to be beneficial and prosperous. I had the opportunity to work in many of the most prestigious medical centers on the East Coast.

It was a constant educational experience and an extremely exciting career. I loved the challenge of going to work.

On the surface it seemed to be a very fulfilling life. I had a beautiful wife and children, a career that was challenging, acquaintances and very few friends. But under the surface a maelstrom was emerging.

Initially, I thought I was experiencing the moodiness that marked my earlier life. There would be times I would become emotionally

distant and withdrawn from my wife and children. For no good reasons I would take to activities that provided isolation, and in that isolation I would find solace.

I always enjoyed reading and would do it in moderation. I found myself retreating to a bedroom with a book and not be seen for hours. Now I would spend hours in reading. I saw no particularly bad side to this behavior. I did not see how I was becoming disengaged from my family.

I also enjoy exercise, which is another isolating hobby. Daily I would go to the gym and spend at least an hour to three hours in the routine of exercise, sauna, whirlpool and showering. This was done early in the morning when the rest of my family was getting up to start the day. I missed the opportunity of watching and helping my sons get ready for school.

I started to work excessively, sometimes being on the staff of three different hospitals at the same time.

Early on it was not all negative. I was

able to spend time with my boys in their activities. I enjoyed being an assistant scout leader and other activities, helping coach my sons sports teams, watching my sons academic and sports progress. I was so proud of my boys, I would do anything for them. They kept me in balance.

Time matched on and my behavior began to change. It also began to fragment. The isolation and detachment slowly progressed. No longer did I look forward to the future, I cursed the present and damned the past.

I retreated to the bedroom of one of my sons now that both of them were away at college. No longer did I retreat to read, but to watch TV.

Progressively, the time spent watching television escalated to 16 hours a day. I loved the History Channel.

I would lie in bed in old clothes often not eating to watch -- often not eating to watch the History Channel.

No more did I get up to help with the meals, clean, laundry, walking or any walking

of our dogs, going out with my family, shopping or caring for our home. I only got out of bed to go to the bathroom, shower occasionally and drag myself off to work.

I began to take off from work. When at work, mostly in the Intensive Care Units, I became lax.

Procedures, treatments and rounds became cursory. The excitement was gone. I really didn't care anymore. I would do what was needed to be done and retire to the locker room to be by myself.

The world as I knew it was shrinking. Time stood still. There was no future, the past was nonexistent, the present was a vacuum where my life was being drained.

Finally, I stopped taking phone calls from my sons.

Sunday night tradition included the boys calling at home to tell us how they were doing in school. I loved those telephone calls. In time, when in bed, that is where I stayed. I refused to get up and talk with the boys.

At this time my wife began to talk about

depression. I vehemently argued that I was not depressed. I did not believe or know that I was depressed. Sure a little blue because I was getting older and the boys were gone, but not depressed. I would know if I was depressed.

She wanted me to see and arranged for a visit to a psychologist within our insurance network which, in itself, is a feat hard enough to do.

I went once, thought she was depressed, and missed the next appointment date all together without an excuse as we continued to debate the issue, not knowing I became worse.

So far, many external things in my life have been lost. The relationship with my wife deteriorated with my wife, deteriorated to nonexistence. Eventually I lost my job, the relationship was poor with my sons, bills and obligations mounted. I didn't really care about any of it, but I knew that I was not depressed.

Once more, through the psychologist, my wife tried to get me into a treatment facility,

but to no avail.

According to the therapist, I was not in any clear and present danger. No hospital or treatment center would take me for admission.

She told my wife if I was to go to the ER or crisis center, she really needed to sell the idea that I was depressed and how sick I was. It was the only way for an admission for me to occur.

Luckily, she didn't have to wait long.

I always believed that the ultimate sin, the unforgivable sin was the loss of hope. If one lost hope, one lost their life. It was the mainstay of living. It allows one to experience the good, the bad in life, and believe in the future.

Now that so many external things were gone in my life, I began to deteriorate internally.

Lost was my ability to love, to care and to feel. My world continued to shrink. I lost hope.

One night I brought home a cocktail of drugs from the hospital, and after calling my wife to tell her not to come home, I tried to

commit suicide.

Everything was dark. I had no feelings. I was not scared and I was not in fear. I had no joy. I had no hope. There were no angels or demons. All I had was a black pall over my life. I didn't recall good or bad, happiness or sadness. There was no thought, no emotion, no experience. I just existed, naked spiritually, emotionally and physically.

I did not die, and for this I was grateful. It also gave my wife the evidence that I now fulfilled the State's requirement of being a clear and present danger to myself and others, and found my way into recovery.

The time has come for the passage of House Bill 2186 as a means of providing compassionate early intervention for individuals with mental illness or those with anosognosia.

Assisted outpatient treatment is a viable option to keep individuals in the community and home while receiving the attention and care they so desperately need.

Studies show it is effective in reducing the number of hospitalizations, homelessness,

arrests, violence, victimization and treatment non-compliance.

Personally, I believe that if this bill was in affect, my life would have been severely altered for the good. Early on intervention would have been more possible and productive.

There are so many lost opportunities for intervention by my family because I was not, according to present legislation, a clear and present danger to myself or others.

Currently, for me to receive treatment, I would have had to seek services voluntarily, and this I refused due to my anosognosia. I just was not depressed.

The damages resulting from a lack of awareness of my illness are tragic, devastating and possibly irreversible.

I lost a marriage of 26 years, viable employment, the love and respect of my boys, self-esteem, and above all, hope. Life was shattered, and I didn't have the will to pick up the pieces. I was desolate, confused, bitter and mean.

It was only when I became suicidal that I

met the State's criteria for hope.

House Bill 2186 would allow for early implementation of assisted outpatient treatment for individuals starting on this slippery slope of mental illness.

Perhaps it can spare them from the loss of love, intimacy, faith, trust, hope of spouses and children. Perhaps it could spare them from the humiliation and desperation of losing viable employment and the possibility of never being hireable. Most of all, it may spare them from the loss of self-spiritually, emotionally and physically. Suicide, crime, homelessness, violence, drug abuse, hospitalizations should not be the benchmark required to receive mental health intervention. House Bill 2186 offers only one thing for the family and individual of those struggling with mental illness, hope.

I was lucky and blessed. Life did not end for me one dark, desolate evening. Recovery was made possible with a lot of work and guidance.

The boys are the center of my life and our relationship continues to flourish.

Volunteer work at the National Alliance on Mental Illness has given a source of purpose and meaning to my life in ways that I never thought possible. It is something that I believe in and it seems to be so natural, not work.

Finally, I can say that I now have a measure of something missing in my life, I have a little measure of peace.

Thank you for your time and your attention.

REPRESENTATIVE WATERS: Thank you, too, and I appreciate your remarks.

And I see why you yielded to him to give his comments.

Any Members have any comments?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: Your remarks will be entered into the record. Do you have written remarks?

MS. STEWART: Yes.

REPRESENTATIVE WATERS: Okay. Do you want to make comments?

MS. STEWART: Are you saying not to present my testimony and move on? What are you saying?

REPRESENTATIVE WATERS: If you can summarize it, please.

MS. STEWART: Well, I am Wendy Stewart; I am executive director of NAMI, Cambria County in Pennsylvania here.

NAMI is the national organization dedicated to improving the lives of people with mental illness and their families.

I have served as executive director for eight years, though I have been associated with NAMI for nearly 25, as I am also the family member of someone who is ill.

My sister suffered her first psychotic break at age 15 and was diagnosed shortly after with schizophrenia.

She has been ill for 44 years and has been involuntarily committed well over 20 times in both community and state mental hospitals, sometimes for many years at a time.

I am no fan of state hospitals and I am no fan of state hospitals that took my sister away

from her family and community, and I am no fan of involuntary commitments being anything other than a last resort and only for the necessary duration of time for someone to become significantly better.

I am, however, certain that my sister's commitments were necessary at the time to protect her when she was ill and allow her to receive the help that she desperately needed.

Conversely, I've also known first hand the frustration of watching an ill loved one refuse help and deteriorate having to wait for them to become ill enough to get treatment.

I can also attest, too, that the single request that we receive in our NAMI office that we receive most often is from family members concerned for their ill loved one who refuses help.

It is of great concern to me that the treatment laws created in 1976, once designed to protect people, have little relevance to the current system of care in 2010, and actually now denied treatment to those who are most ill.

We are all here today for the same reason.

We all feel passionately about helping individuals with mental illness.

NAMI, Cambria County, is one of six affiliates that have signed resolutions in support of this legislation. Attached to my testimony is the -- are the six resolutions of support.

We believe that when all else has failed, and only when all other interventions have been exhausted, court ordered treatment that allows one to remain in their community is humane and compassionate if a compassionate response that would spare tremendous suffering and possibly save lives for someone whose history indicates a pattern of further deterioration implementing assisted outpatient treatment could break the cycle before they have reached a clear and present danger. Because in an instant, clear and present danger can simply be too late.

Currently, when after all efforts have been exhausted and an individual continues to refuse treatment, there is really nothing that can be done other than to wait until that person deteriorates far enough, this is when

the person most likely is going to act out to a misdemeanor offense that is going to land them in prison, and thus begins the whole matriculation through the Criminal Justice System. It is a tragic outcome of untreated mental illness.

For those who eventually do reach the current standard of clear and present danger, the option of outpatient commitment in the community is one that few doctors would consider because of the risk.

How can you want to put somebody who is a clear and present danger out into the community? I mean, that's not fair to the person, and that's too great a risk for the community, for everyone involved.

The other thing that you need to consider is the hospitalization. Having that be the only other responsible option, the consideration of the critical shortage of hospital beds in Pennsylvania and the inability to provide sustained treatment.

The shortage has put very many ill people back out into the community long before they

are ready.

An average length of stay now is less than a week, and that's even under involuntary commitment.

For someone deemed ill enough to require hospitalization, the way to get into the few remaining state hospitals can take months.

With current efforts to close state hospitals and de-institutionalize care, this resource will soon be a thing of the past. A great concern when so few beds exist in the community.

Utilizing outpatient commitment after a short hospital stay is another way to possibly ensure an individual continues treatment long enough for them to realize life might be working better.

This proposed legislation could make a difference for those who, because of their illness and refusal of treatment, may stand to lose everything, like Curt, their livelihood and their homes, their families, and sometimes their lives.

Passage of this legislation should not be

confused with loss of a person's freedom. The people this legislation would affect aren't free to be here today, they're already in prisons, they're already cycling repeatedly in and out of hospitalizations on locked units, they are already wandering the streets and eating out of garbage cans or they've lost their lives to an illness they never asked for. That is a freedom no one deserves.

These individuals have a right to be well and they, too, deserve a chance at recovery.

It is unconscionable to accept their condition in the name of protecting their right to self determination. Nobody aspires to live this way.

I want to point out that NAMI's policies at the national level, they are very much aligned with the proposed legislations. And this is also an attachment.

When you have time later, please review both the NAMI policies.

This is at the national level. These policies have been in place for at least 15 years in support of assisted outpatient

treatments.

On one final note, I am from Johnstown in Cambria County and live in a more rural area out in West Central PA. While no doubt that we're struggling with the economic downturn and we would clearly benefit from a broader array of services, it is my job to know about services offered throughout our county and all throughout the state.

NAMI routinely invites service providers from our county to our meetings to explain the services they provide and to hear their presentations, to read their pamphlets or visit any of their Web sites detailing the services that they offer. There is little indication that the very few individuals who would actually meet the very stringent criteria for an outpatient commitment could not be provided for.

We have existing services, including Intensive Care Case Management, Partial Hospitalization, Psychiatric Rehabilitation, Peer Support Services, Mobile Mental Health Crisis, Drug and Alcohol Services, Supervised

Residential Services and a Police Crisis Intervention Team. These are all services that could help provide support for these individuals.

If Cambria County can, I believe that most other areas can. Surely Philadelphia and areas like Pittsburgh would have much greater numbers of people that would be qualified for assisted outpatient treatment. For Cambria County it might be an additional seven, eight people tops.

But, again, Philadelphia and Pittsburgh receive more funding, and they have even more services, and they have some of the best programs out there that can meet the needs of these people.

In closing, I ask you to thoughtfully consider, if you knew five years from now that you would be standing naked preaching gospel in a city park or were dirty, cold and eating from garbage cans or tormented by surveillance devices implanted in your body and the devil speak to you through the TV, would you all want someone to help?

Please follow your hearts and do the right thing here.

Thank you very much.

REPRESENTATIVE WATERS: Thank you.

Any questions from the Members?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: Thank you so much.

All right. Now we want to ask Debbie Plotnick and Alyssa Goodin, please come forward.

And in the interest of time, because the Members are beginning to leave, could you please be as brief as possible. I know that it is important. This is very important.

MR. CHAIRMAN: It is not that they are not interested, what they have to do is getting out of Philadelphia, especially this time of the afternoon.

MS. PLOTNICK: We do indeed. And Joseph Rogers will be very brief.

MR. ROGERS: Hi; my name is Joseph Rogers, and I am chief advocacy for the Mental Health Association of Southeastern Pennsylvania.

Very briefly, I think one of the things that I would like to ask that you really look at closely is the cost of this legislation. You heard it's not going to cost anything. Well, that is just sort of against logic.

As Representative Cohen said, what the underlying purpose of this legislation is to change the commitment standard not only here in Pennsylvania, but nationally.

This is a campaign that's been orchestrated by the National Treatment Advocacy Center out of Washington, D.C., and that's their goal ultimately is to change the commitment standard.

And whether you believe in that or not, I, you know, I don't think that we need to change our commitment standard, but let's say we do need to change our commitment standard, then we need to fund them because, obviously, if you're changing your commitment standard, you are going to commit more people. You're going to expand the number of people under involuntary treatment, which is the most expensive, even outpatient involuntary treatment, if it's done

right, is the most expensive way to treat somebody.

So what I would ask the Committee to do is really look at, and seriously look at the issue of cost.

In New York State, to properly implement Kendra's Law, which this law is based on, they've budgeted around $130 million.

Now, in our present budget climate, can we get $130 million? You tell me. Do you think that we can get an additional $130 million for mental health services?

That's what it would take to properly do this law, not just put people under onerous court orders and commit them to not being -- commit them to air, but to commit them to serious programs that are going to do the serious follow up.

I am a person with a diagnosis of mental illness. I have bipolar disorder, and my illness is, at times, not manageable by myself, and what I need when I'm not in management myself is psychiatrist care. I need a -- luckily, I've always had private insurance and

I am able to get those things. I need, you know, friends and case managers to follow me up. All of these things cost money.

So, if we're going to expand the commitment law, which is ultimately the goal of this bill, then let's expand the resources available.

And I say if you expand the resources available, we probably wouldn't have to change the law.

So -- and I know that this Committee would be in 100 percent in support of the necessary development of revenue and increasing the income tax so that we can have the revenues to vigorously treat and make sure that people don't fall through the cracks and get the services and treatment they need.

So, that is, for me, the issue here, if we're going to change the law, let's really take a serious look at what we're doing and not do something halfway.

Thank you very much.

REPRESENTATIVE WATERS: Thank you.

Will you give your name? It is clear to

see who the gentleman was.

MS. PLOTNICK: Certainly. I am Debbie Plotnick, and I'm the director of Mental Advocacy of Mental Health Association.

I will abbreviate my remarks.

I wanted to talk about -- many of the folks in this room and many Members of the Committee have heard me testify before of other venues, including this one and speak about my daughter. So I wanted to speak also as a family member.

And I wanted to make clear, that what really informs me more than my professional credentials, and I have a Masters Degree in Social Work, like many of the folks that you've heard from today, I also have a Masters Degree in Law and Social Policy, but it is my experience as a family member of a daughter with bipolar disorder and a father with bipolar disorder and working with folks who are in recovery have formed my perspective on my position more than anything else. It is my lived experience in addition to my credentials that make the big difference.

You've heard heart wrenching testimony. This is why I do the work that I do, because my heart breaks, too. And I know what it is like. I personally know what it's like to be in so much pain. I know what it is like to be afraid that you don't know where your loved one is.

I have been through so many hospitalizations with my daughter. I have cleaned up blood and guts and things that you don't want to talk about. I have looked for my daughter. I have been ready to do anything to protect her. And it is so scary.

And I know what it is like to experience tragedy. And sometimes we can prevent tragedies, and sometimes we can't. We do have to minimize things. We have to work hard to prevent what we can, but knowing that we can't always prevent things.

Good people with honorable intentions would do anything. And here we are, and tragedy has still happened.

I talked about my daughter. Her name is Ashley. And as I said, I have been there and have done that.

I want to tell you about my daughter, because she is the bravest, most resilient person I've ever, ever met in my life. And she has taught me more than anybody else has ever taught me.

Today she has a college degree, she is a registered nurse, she works as a hospice nurse, she married her high school sweetheart.

And he was a young man in recovery himself. He suffered from depression and had a substance use disorder in his teenage years and early adulthood.

And my daughter was tragically widowed a little more than two years ago. She was 25 years old.

My two kids, my daughter, Ashley, her husband, Jim, they were amazing. They were amazing young adults and in recovery with a serious mental health condition and substance use disorders.

As I said, she was a nurse and he was in law school. He just started law school.

And they were hit by a car while riding their bikes outside of Albuquerque and he was

killed.

As I said, sometimes we can prevent tragedies, sometimes we can't. And they are terrible and they are heart wrenching.

But I learned from my formerly suicidal daughter, who is widowed, and she continues to show me the choice and self-determination are what is really, really necessary, and that individuals, then, when they have that, they can and they do choose life, even when they are suicidal, when they have been formerly suicidal or they are tragically afflicted with a broken heart, as was my daughter.

My daughter has taught me that the only way you can truly help a person who is suffering is by listening and respecting their autonomy and for choice and in self-determination.

And that's why I made my life's work what it is. And my life's work is to give people that autonomy and self-determination, but it is also to create the opportunity for things that they will choose.

In our division in advocacy, we develop

wonderful programs. We work to make the linkages. We work to put in place more of what we know works, peer teams, ACT teams, the patient training, housing.

You've heard Mr. Meek talk about housing, it is the biggest issue that we do. That's what our division works on. How do we link people to what they want; what they feel comfortable; what they will accept; and how do we wrap services around the community?

You've heard other testimony today about how medications help. Well, they do help. It is not easy to find ones that do help.

And people who take psychiatric medications stay on them at exactly the same rate as people who take any other kind of medication. It is about 50 percent of the time that they are so-called compliant with medication regimes, because it takes such a long time.

My daughter at one time was on eight, maybe ten different medications, and what happen was, she would horde them and have a suicide attempt with them.

And -- so, clearly, it is not the only answer, it is a tool. We've got lots of tools.

And you've heard today how we don't use our tools correctly. We don't use the laws that we have correctly. That's what we work to change. We want to see the existing laws applied better. We got outpatient commitment, and we're not using it enough.

What our team of advocates goes out and works with OMHSAS and works with the community and work with the providers to educate them to get them to use the tools that we have.

That's what caring parents do and caring society, we link people to what they will use to what we get more of what will help, what people will choose. We don't tighten things up more so that we're intentionally in violation of not only their wishes, but their constitutional rights. Yeah. We love them.

Nobody loves more than the parent, but we really need to have more resources and more education. And we're so thrilled that OMHSAS has been taking this as seriously as they are.

And the draft regulations, the draft

bulletin, I'm sure that you've taken a look at it, it really speaks to changing our perspective to putting, literally, the cart before the horse, to using commonsense, to not waiting until people are dangerous to themselves or others. We don't have to.

You've heard Mr. Meek talk about the other part of the law.

So, what we're working for is, we go out into the community and we work with the community and with counties and with legislators, is to get them to put in place what we need so that we can better use our existing laws.

You've heard testimony, heart wrenching testimony about how, if we had used our existing laws better, things would be better.

Well, that's really, really true. We don't need a new law. We don't need a law that goes for likely, because who can say likely?

When my daughter was doing fine and everything seemed fine, she would have a suicide attempt like that. You can't predict, nobody could predict, because if we could, we

would if we could predict what would happen.

What we do know is, when people need help, we got to make it available to them. And that's what we are really asking for. We're asking for the support from our legislative members to say, yes, put money behind the services. We were more peer outreach teams.

We just developed a program in Philadelphia we are very excited about, that peer specialists are going to meet folks who have repeated cycles like you've heard, meet them when they're still in the hospital and they're coming out to help lead them right away to community services to help them get to their appointments, to give them the support to say, I know what it's like. I have been there; I've done it and I can help you through the process. And that's becoming an evidenced-based practice, having peers to do that.

So, I ask you very seriously as you look at this, to not be redundant in having another piece of legislation. It is really unnecessary. Let's help sure up what we got by, yeah, in this budget climate it is going to

be hard, but are we going to fully fund? No. But looking carefully at how many cuts and helping us educate on using the existing law.

And I want to say thank you for your deep, deep caring, because it really shows. We are all here because we care.

Thank you.

REPRESENTATIVE WATERS: Thank you.

Do you have testimony?

MS. GOODIN: Yes. I do, but I will try and hold to it.

REPRESENTATIVE WATERS: State your name.

MS. GOODIN: My name is Alyssa Goodin and I am the Children's Systems Advocate at the Mental Health Association of Southeastern PA. I'm also a family member of somebody who is living with a mental health condition, a social worker and a citizen of Philadelphia.

I have serious concerns about legislations which may criminalize mental health conditions and rob Pennsylvania citizens of their autonomy.

As a family member, I understand the fear of losing a loved one and the willingness to do

whatever it takes to make sure they're safe.

My sister Katie was 15 years when she was diagnosed with bipolar disorder.

The next three years were devastating to my family.

My sister's rapid mood swings and irrational behavior were frightening, confusing and frustrating for all involved.

A flurry of suicide attempts and hospitalizations left us living in constant fear of the day that we would lose her.

My mother eventually quit her job to stay home in attempts to ensure my sister's safety.

During Katie's worst attempt, my mother witnessed Katie stabbing herself in the stomach for which she required surgery. Luckily she survived.

But, at 18 years old Katie would become a legal adult and we faced the fear and uncertainty of her being able to make decisions for her recovery.

Certain that she would choose to no longer take her medications, see a therapist or utilize other coping skills, we were terrified.

We thought of all the worst scenarios, she would become homeless, begin using drugs, wind up in prison or dead.

Fortunately, we were wrong. As an adult, Katie made the choice to actively work on her recovery, complete high school and maintain a full-time job.

I believe that Katie's life would look very different if she had been court mandated to attend treatment and forced to take urine and blood tests to prove her adherence to medication.

Such practices are dehumanizing and would have robbed her of her autonomy and ownership of her own recovery.

Imagine if an individual with a heart condition was forced to take blood tests to prove that he hadn't been sneaking that last Twinkie. Wouldn't that rob him of a certain level of dignity and choice? And wouldn't that make visiting the doctor a very unpleasant experience, one he may not be invested in or wish to continue?

My experience as a social worker has also

informed my opposition to this bill. As a social worker who has worked with people with mental health and substance abuse conditions, I understand the difference in treatment outcomes based upon an individual who has choice in their treatment plan and is invested in that work, and an individual who is coerced and not invested.

Working with court-mandated clients has taught me, while a court can force someone to be physically present, that individual will never be truly invested in his or her treatment unless he or she chooses to be.

In fact, in my experience, mandated treatment is frequently more harmful than if the individual had had no treatment at all. It alienates people.

I've worked with many individuals who are opposed to ever returning to treatment because they associate it with coercion and force.

As Debbie said, we understand this is a bill of good intentions, but we believe that there are other ways of achieving these outcomes.

As Debbie was saying, and I also agree, that we need to implement the current existing law in a more effective way.

And I also believe that we need to fund the services which we know work. Fund certified treatment teams and certified specialists that we know are able to go out to the streets, to homes, engage people in their treatment. We know that's more effective.

So, in conclusion, I ask that you oppose this potential harmful bill and, instead, to advocate to maintain funding for the effective services which are so badly needed during these difficult economic times.

Thank you for your consideration and your time.

REPRESENTATIVE WATERS: Thank you, too. Thank all three of you for coming in.

I would like to ask any Members if they have any questions?

Representative Seip.

REPRESENTATIVE SEIP: I will be brief. I will be very brief, Mr. Chairman.

But I do appreciate your testimony, and

certainly what you just said is a list of --

MS. GOODIN: Yes.

REPRESENTATIVE SEIP: Okay. What you just said I think is very key. You know, patients who fall through with their heart medication or diabetic conditions or whatever, people say, oh, my goodness, that's horrible, you had a stroke or you had something very bad physically happen to you.

Often, and, unfortunately, mental illness isn't looked at the same way. And I think people are eager to get off of their medications. The compliance rates, maybe they are the same, but I think that's probably because people just don't want to be mentally ill, because there's such a negative statement to it, you know.

People, I think, get on these regimes and they get to a point where things are going very well in their life and they say, oh, I got to stop taking that Clonopin, people think I'm crazy, or there is something wrong with me, or I am bad, or I am a bad person, I guess, because of that stigma.

People don't think people are bad persons because they had a heart attack or because maybe they had one to many Twinkies, something like Alyssa had said.

So, I think that that's probably an important point that we want to try and continue to educate the public on, that, you know, they aren't bad people because they have a mental illness.

MR. ROGERS: And I think you make an excellent point. Even in the current law or the present law, when you are having problems with the compliance or adherence to your treatment, there are new medications, new technologies that can help you with your adherence.

There is a thing called Risperdal Consta, which is a drug that is injectable and it's really great, new technology, but we don't have the money. It cost more money. These drugs are more expensive, so we don't -- we don't have people being able, who want to, who are asking for, who are working with their doctor and the doctor says, this is a person who has a

problem with adherence, getting access to these medications.

So, again, I plead, that when you look at this very complex issue, before you start tinkering with something that, you know, people are working on for literally hundreds of years, that we need to look at things like, how do we fund the new technologies that are coming down that allow a person to have the adherence, because a lot of the adherence problems are not something where the person's brain is, you know -- I have bipolar disorder and, you know, my adherence problems come as much, because of economic situations, the ability to access medication, the ability to -- I go to my pharmacist, and I'm a person with resources, I'm a person that's knowledgable to go to my pharmacist.

My drug company -- my insurance company has decided that my drug is no longer on their formulary, and I'm standing there, run out of medication and I want to get the medication refilled and the pharmacist says, you know, we can't fill your prescription because it is no

longer on the formulary. That's why we end up with people not adhering to their medication. One reason at least.

So we need to address these very complex issues.

And I think that this tinkering that we are doing with a few words in language doesn't address that.

REPRESENTATIVE SEIP: I was not too far from here a few years back at Veteran's Stadium and Jim Eisenreich was talking with a group of children there that had come to see him before the game. And, you know, there's a guy who was very successful.

He said, you know, he opened it up for questions and one of the first questions from one of the children, what kind of medicine do you take? And Jim says, well, you know, this works for me and it may not work for you, but I've been taking Klonopin and Haldol and it's been working very well.

So, you know, I think, that because we have people like Jim Eisenreich out there saying, you know, I have a medical condition

and now I've overcome that and, you know, I'm doing okay.

And because of people like yourselves willing to come here and testify today, I think that all helps with our community education.

So thanks for being here today.

Thank you, Mr. Chairman.

REPRESENTATIVE WATERS: Any other questions from the Members?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: And thank you, all three of you, for being here.

As you see, this is a work in progress. It is possible that it may be new legislation, it may not be necessary, but one thing for sure, we are bringing this issue forward. And while we're bringing it forward, funding always has been an issue, but answers is what we really need, and you have provided us with a lot of good answers and good recommendations.

So, thank all three of you for being here.

MR. ROGERS: Thank you so much for caring. Thank you.

REPRESENTATIVE WATERS: Thank you.

And, now, we're asking for the 12:45 presenters to come up, and that is Richard Heep, Ph.D, and Jeanette Castello, Pennsylvania Treatment Law Advocacy Committee.

Thank you both for being here, and we are going to wrap up after you give your testimony.

Thank you.

DR. HEEP: I don't represent a group, I am a private practitioner and I treated Jeanette's daughter when she was in her early stages of schizoaffective disorder.

And over the years, since then I've met a few other youngsters who have the condition known as anosognosia, it is as hard to pronounce as being on the drug, and I actually thought that I should do something about what was going wrong with her treatment.

And I learned from Jeanette that was something called AOT, and I wrote a long letter to the Pennsylvania Psychological Association to maybe get them on board with advocating for this AOT. This was awhile ago.

I believe that there are members who would

back this up and there are some that wouldn't. But in other states, other psychological associations have AOT laws.

And, anyway, I am speaking for myself, and maybe in time if it is necessary to wait for the Pennsylvania Psychological Association, maybe they would back this up, but hopefully we don't have to wait that long.

The purpose of my writing this and testifying is to encourage Members of the Committee to vote in favor of 2186.

My perspective in the mental health field is as a clinical psychologist with over 30 years experience in the treatment of mental and emotional disorders of children, adolescence and their families. My work also includes clinical program director, treating psychologist in mental health and mental retardation centers as a private practitioner in the educational field as an adjunct faculty in the Penn State University.

My main interest in talking is to talk a little bit more about anosognosia and my concern for the fate of this population.

It is a small sub group of the non-compliant population, and these patients often suffer schizophrenia disorder and bipolar disorder.

And along with the psychosis they have a condition that is best described by Dr. Amador, who is the author of, I Am Not Sick, I Don't Need Help.

The condition is known by the term anosognosia, with non-compliance. The psychological treatment of pharmco therapy becomes a manifestation of this condition.

The patient has an unmistaken mental illness, but is currently oblivious and is showing its existence and not improving and they refuse to be treated. This is accompanied by an inevitable bound of psychosis and the loss of reality testing.

Anosognosia is a condition probably deriving from a biologically-based E fact in the right hemisphere. So the research points to that. Doctors refusing this research.

This condition, coincidently, does co-exist with senile dementia, which has an

indisputable organic origin. It is hard to believe in this condition for some people.

I mean, I know nothing of it myself. I, personally, think that I am pretty much aware 24 hours a day of what I'm doing and I am aware of my condition. And the patients with anosognosia don't have that benefit. They simply don't acknowledge the fact that they're in trouble.

Improving treatment services for these individuals really does not seem to be the answer.

Although, it is generally the next step in the mental health field because it improves services, but these particular patients steadfastly deny their problems and resist the necessary services.

AOT services are really designed, to some extent, to help this particular group of patients that just repeatedly deny having a problem, stop their medication, they get into trouble, go to prison, wind up on the street or in some other tragic situation.

The Pennsylvania legislature in its Mental

Health Act of 1976, provided a court ordered treatment for people with severe mental illness in both an inpatient and outpatient basis.

The standard for involuntary commitment was clear and present danger, as you read today, that if somebody has a clear and present danger problem, they really have to go into an inpatient facility, and we have to wait until they reach that level. There is really not too many choices. Many doctors won't take any chances with someone like that.

HB 2186 does change the standard and allows for looking at patients and looking at their history.

I think that there is a question, can we really predict mental behavior? That's the problem.

I think there are some misses even when you try to deal with these individuals. They really quite predictably deteriorate when they stop their medication. They really need that kind of help, and they do need the help of supportive services in the form of psychotherapy and so forth.

The opponents of the legislature hold forth that AOT advocates human rights and freedoms, and involuntary commitment procedures are expanded to include non-compliant patients who have only become a clear and present danger.

That is a real -- that's the area that we are looking at. That's the area where we try to pick up on somebody who is showing some really signs of deteriorating, rather than waiting for them to do something terrible.

You know, human beings in our society, and we feel in our core values in human beings should be responsible for themselves and have a right to self-determination.

However, when a non-compliant patient stops medication, they all too often migrate into the homeless or prison population, commit suicide or ignored and abused.

They get there not through free rationale choices, they are the byproducts. These are the byproducts of mental illness.

AOT procedures are implemented to avoid predictableness upon himself or others.

I don't see AOT as an advocation of human rights, but more correctly as legalizing an action designed to help psychological rationality, to free a patient from the demons that interfere with and serve the country pretty well.

Consider it this way, AOT, rather than being an instrument of depression, which it has been referred to even today, should be viewed as a means to release depression from the grips of an active psychotic state, which diminishes, truly diminishes free will.

Amending Pennsylvania's mental health by means of HB 2186 appears to be a crucially important step along the way to strengthen our mental health system.

I believe AOT will correct the loophole and promotes action where necessary and which causes clinicians and families to stand by helplessly watching their loved ones with anosognosia deteriorate.

With luck, these patients will reach the criteria of clear and present danger and qualify for involuntary commitment without a

lot of tragedies occurring. We can live a strong and well designed AOT procedure with unpredictable tragedies.

Our courts should be empowered to deal with specific types of non-compliance as described and enforced with AOT commitments. And this is primarily with the patients with anosognosia.

Over the years I had a number of patients who have fallen into this category, and I think that I am basically a pretty supportive person and a good listener, and I really found that even with a lot of patients, that we should be patient and we should wait. We don't have to have somebody admitted with a problem immediately. But these patients, they seem to go on for years and the condition, the end result of depriving themselves of treatment and fall into prisons and homeless and so forth.

Thank you for the opportunity to speak.

REPRESENTATIVE WATERS: Thank you, Dr. Heep. Thank you for your testimony.

You may proceed.

MS. CASTELLO: Thank you, and I will be

happy to tell you this is so important to me.

REPRESENTATIVE WATERS: Thank you.

MS. CASTELLO: Thank you for the opportunity. I appreciate the opportunity.

I became involved in this advocacy effort because of my personal experiences 10 years ago trying desperately to obtain help for my daughter who has a diagnosis of schizoaffective disorder and who also has anosognosia, a lack of insight of the symptoms of her illness with the consequences of not recognizing the need for treatment.

According to the Diagnostic and Statistical Manual of Mental Disorders, which is the DSM, a majority of individuals with schizophrenia lack insight regarding the fact that they have a psychotic illness.

Evidence suggests that poor insight is a manifestation of the illness itself, rather than a coping strategy.

So, I would really like it, if nothing else, for you to go home with today, anosognosia is so significant. Honestly, if it didn't exist, if that wasn't a problem, we

probably wouldn't be sitting here today, all of us testifying. But it is so significant and has such an impact, I hope that you will keep that in mind.

My daughter is a beautiful, intelligent young woman, was a straight A student and National Merit Scholarship finalist, one of 10 out of her high school class of over 800, she was involved in many activities. It appeared that she would have a golden future, and the most difficult problems that she would have to face was deciding what was going to be her major for college.

Instead, she was faced with a diagnosis of schizoaffective.

And after her first psychotic episode in her first month of college, she very reluctantly first took medications, but after a few years she stopped, and within a period of a year and a half she was hospitalized 15 times. The last 15-month stay at a state psychiatric hospital.

Each time she was hospitalized was preceded by the same scenario: stopping of

medication, slow decompensation over days or weeks, including psychotic symptoms of hallucinations, delusions and paranoia, some type of crisis situation that lead to some act that fit the description of clear and present danger, then this revolving door of hospitalizations began over again and again and again.

It was a terribly heartbreaking experience for everyone in our family to witness as we could only stand by helplessly waiting for her to reach a clear and present danger level so that she could finally receive the medications that were effective when taken consistently.

All this occurred simply because our outdated treatment laws required the same standard for both inpatient and outpatient treatment, and that standard is too high.

So, for those saying, oh, let's just dust off our old 34-year-old law and see what we can make of it. Try and keep in mind, 34 years it hasn't worked.

I think the definition of insanity is trying the same thing over and over again with

the same result.

This current law doesn't work, won't work because inpatient and outpatient is clear and present danger. Makes no sense.

If HB 2186 had been in place after two of those hospitalizations that my daughter had, and because she would have met all of the other stringent criteria required in order to be on a court ordered AOT, she would have met the likelihood of clear and present danger and could have avoided most of the other crisis situations and hospitalizations and remained at home instead of being institutionalized.

Because of the objections is, that the reason -- excuse me, HB 2186 shouldn't be considered is because there are not sufficient services or programs available, and that would be to expensive to provide.

However, lack of sufficient services or programs is not a valid objection.

According to the National Alliance Grading State Report of 2006, Pennsylvania is the second highest in per capita spending for mental health services in the nation.

As one of the wealthiest states in this area, we should certainly be able to provide treatment to those who need it the most, who suffer needlessly, not because services and programs are not available, but because an outdated law states, unless you have full awareness of your need for treatment, you must do something to show that you are a clear and present danger.

That standard is the reason many people with severe mental illness do not receive needed treatment, not lack of services and programs.

All this legislation will do is ensure that the people who are the most sick are not the people least likely to receive the benefit of existing programs and services.

Pennsylvania -- I have to very quickly read this because of what was stated about the cost of New York's Kendra's Law.

Many of the estimates or the need for funding AOT in Pennsylvania have been based on false claims on what New York spent to implement Kendra's Law.

Most egregiously, New York's alleged spenditures are calculated by including 125 million general allocation for mental health services in 1999. They came three months after Kendra's Law was enacted.

Keep in mind, again, that we are the second highest in mental health spending, and these New York funds were designed to enhance existing services, case management, housing, children's programs, et cetera.

This 125 million had little to do with AOT other than some of those services may, at times, be used by people in AOT who are only a tiny percentage of those using such services.

So that huge sum wasn't meant just for AOT. Again, provided services for many people.

As a member of the OMHSAS ACT Workgroup last year, I learned that there is already a commitment by OMHSAS to continue to expand the ACT programs.

OMHSAS is also to be commended for ensuring that these programs have fidelity to the original ACT model by hiring an ACT National Consultant from Wisconsin.

This will ensure that the key components of this program intended with severe mental illness will include 24/7 crisis support 365 days a year, and services by a multi-disciplinary team of professionals, including a psychiatrist, nurses, drug and alcohol specialist, vocational specialist, peer specialists and other clinicians.

Seventy-five percent of the services are provided right in the community.

I think it was mentioned, the ACT program in Wisconsin has 25 percent of their people in this program that's been around for 30 years, a perfectly run ACT program still relies for 25 percent either to be on a court order or on parole. Even with the best program available still needs that.

The cost keeps coming up. The cost for one client in an ACT program each year is approximately $18,000. The cost for my daughter to spend 15 months in a state hospital was about $120,000.

Our State coffers lost about $100,000 that year on an expensive inpatient treatment when

they could have provided that same treatment in an outpatient setting in the community.

ACT is known as a hospital without walls.

My daughter supports this advocacy effort for HB 2186 to become law and wishes she could have avoided that time in the state hospital, which was a horrible experience, and had the opportunity instead to have received that treatment on a court-ordered AOT while still living at home.

My first advocacy effort was for the ACT program in our county, and we currently have 62 clients in the program.

The program can admit up to 120 clients. There is room available.

Should HB 2186 become law, this program could easily admit the six or seven people who might meet the criteria for court-ordered AOT.

And that number is determined by the analysis of approximately 500 people who might need AOT.

Since we're the second highest in expenditure for mental health in our country, if there are any perceived problems with the

way we spend our mental health dollars, shouldn't we just take a look at our budget? Are we spending money on the programs that are appropriate? Are there programs that are available for those individuals who are this very ill?

If HB 2186 doesn't become law, it will definitely be less work for some of the providers of mental health services in our communities who would continue to only provide care for those who are able to seek treatment because they are aware of the need for treatment.

Instead, the responsibility for treatment will continue to rest with crisis emergency rooms, hospitals and prisons.

And in case you don't know the figure, 300,000 people with mental illness are in prisons and jails versus 70,000 in psychiatric hospitals.

So, prisons have become our new mental health hospitals.

The major impact of not amending our outdated Mental Health Procedures Act of 1976,

through HB 2186 will be the continued neglect of those individuals with severe mental illnesses through no fault of their own or are too ill to ask for help themselves.

And, of course, it will be the sole responsibility of families who will continue to do everything they can to help their loved ones, but are relegated to stand by helplessly because of the limits placed on their ability to help due to our current treatment law.

As a family member and advocate for this compassionate intervention legislation, I ask that you please help those who need the most help and vote for passage of HB 2186.

Thank you.

REPRESENTATIVE WATERS: Thank you.

Thank you, too, for your testimony.

Representative Cohen.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

This bill, House Bill 2186 does not mention anosognosia at all; should it?

MS. CASTELLO: And I'm going to apologize because I do believe that it refers to lack of

insight, which is anosognosia.

REPRESENTATIVE COHEN: Okay. Should it be clarified that that is the same as anosognosia?

MS. CASTELLO: It is, yes. Anosognosia does mean the same, lack of insight.

REPRESENTATIVE COHEN: Okay. Doctor, do you agree with that?

DR. HEEP: I think there is, I think, a more of an organic component to anosognosia then insight is more of a psychological phenomenon that all of us can have trouble with, that all of us don't have organic difficulties.

So, I think it should use probably both terms, but anosognosia, I think that should be --

REPRESENTATIVE COHEN: Anosognosia would be more precise?

DR. HEEP: Yes.

REPRESENTATIVE COHEN: And there would be civil liberties, the problems, perhaps, if that were a more precise term in the bill?

DR. HEEP: Yes. Um-hum.

REPRESENTATIVE COHEN: I thank you,

Mr. Chairman.

REPRESENTATIVE WATERS: Thank you. And thank you for bringing that up, too, Representative Cohen.

Any other questions?

(Whereupon, there was no response.)

REPRESENTATIVE WATERS: Okay. So, now at the end, we have finally reached the end, just behind schedule.

I want to thank Representative and Chairman of the Health and Human Services Committee, Frank Oliver, for having this meeting, and I also want to thank all the testifiers who came here with the very moving and informative presentation.

I hope that this, at this time, together we will help move forward in getting more meaningful policies addressed in this very serious, very serious issue.

Thank you for the research that you provided of loved ones at home and to your neighbors and the challenges and that you are working under a very challenging circumstances.

We definitely see that.

You are on the front lines. We want to all work together to better effectively help mental ill people, give them the help they need to live better and a more satisfying, safe and productive lives.

Please have a safe journey home, and this hearing is now adjourned.

Thank you.

Let me thank the Members for being here. All Members for presenting great questions and taking all of this time.

We will have another hearing in Harrisburg, so please be aware of that.

(Whereupon, the proceeding was adjourned at approximately 2:15 p.m.)

C E R T I F I C A T E

I, RENÉE HELMAR, a Shorthand Reporter, and Notary Public, certify that the foregoing is a true and accurate transcript of the proceedings which were held at the time, place and on the date herein before set forth.

I further certify that I am neither attorney, nor counsel for, nor related to or employed by, any of the parties to the action in which these proceedings were taken, and further that I am not a relative or employee of any attorney or counsel employed in this action, nor am I financially interested in this case.

Renée Helmar

Shorthand Reporter