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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: A Public Crisis –
The Battle for Mental Health Treatment vs. Mass Incarceration
Yeadon Borough Hall – Yeadon, PA
November 27, 2017

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panel One:

- Marilyn Benoit, MD, SHSA
  Senior Vice President, Chief Medical Officer, and Chief Clinical Officer
  Devereux Advanced Behavioral Health

- Susan Rogers
  Director of Special Projects/Advocacy
  Mental Health Partnerships

- Andrew Wiglesworth
  Executive Vice President of Wojdak and Associates
  Treatment Advocacy Center

2:50 p.m. Panel Two:

- Tracy Halliday
  Mental Health Director
  Delaware County Office of Behavioral Health

- Lynn Patrone
  Mental Health Advocate
  Pennsylvania Department of Corrections

- Scott Bohn
  Chief of West Chester Borough Police
  Vice President of Pennsylvania Chiefs of Police Association

3:30 p.m. Closing Remarks

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House Co-Sponsorship Memoranda

House of Representatives
Session of 2017 - 2018 Regular Session

MEMORANDUM

Posted: February 2, 2017 02:43 PM
From: Representative Margo L. Davidson
To: All House members
Subject: Mental Health System Reform Legislation (Re-Introduction)

In the near future, I intend to re-introduce a legislative package that will strengthen community mental health crisis response systems and treatment programs to ensure individuals with debilitating mental illness receive the treatment they need. With the recent passage of the bipartisan federal 21st Century Cures Act, it is imperative that we do everything we can to increase access to mental health treatment programs and help families receive the supports and services they require to assist loved ones in crisis. These bills can finally bring parity for illness that affects the brain as well as the body.

Therefore, I ask that you join me in co-sponsoring this important package of legislation that aids individuals within the Commonwealth who are in need of specialized treatment for their mental illnesses. This package of legislation will assist individuals living with serious mental illnesses in our communities thrive and invest in practices that help break the cycle of mental illness, incarceration and inadequate care.

Bill #1

The first bill – former House Bill 1630 of the 2015-16 Legislative Session – would codify the standards and guidelines for assertive community treatment (ACT) created by the Office of Mental Health and Substance Abuse Services within the Department of Human Services. Similar to the guidelines, this legislation will provide for the establishment, organization, treatment, and evaluation of ACT services.

ACT provides long term community based, highly individualized care for individuals suffering for serious and resistant mental health conditions. An evidence-based, best practice, ACT involves a multidisciplinary team providing assertive outreach to individuals who are most at-risk of homelessness, crisis and frequent hospitalization, and involvement with the criminal justice system. The federal 21st Century Cures Act specifically authorizes grant programs to establish and operate ACT programs and other early intervention programs.

Bill #2

The second bill – former House Bill 1629 of the 2015-16 Legislative Session – would amend The Insurance Company Law of 1921 to require insurance companies to provide health insurance coverage for ACT for individuals with serious and persistent mental illness. Currently insurance companies only cover 3 types of treatment – Hospitalization, Partial-Hospitalization and IOP (Intensive-Out-Patient). This harmful treatment gap means that prisons have become the mental hospitals of the day and they are ill-equipped to provide appropriate care nor should they.

Bill #3

The third bill – former House Bill 2512 of the 2013-14 Legislative Session – would amend Act 143 of July 9, 1976, known as the Mental Health Procedures Act, to require facilities to notify an individual's next of kin, including their spouse, parents, or children, ir the event that their relative has been admitted to a mental health facility as a result of a mental health incident.

Bill #4

The fourth bill – former House Bill 2514 of the 2013-14 Legislative Session – would amend Act 153 of 2004, known as the Pennsylvania Amber Alert System Law, for the purpose of requiring the Pennsylvania State Police to operate the Missing

Endangered Person Advisory System, just as they would the Amber Alert System, and requiring coordination with various state and federal authorities for the recovery of missing children and missing at-risk individuals.

Members are free to co-sponsor one or all four bills in this Mental Health Reform Package.

House Co-Sponsorship Memoranda

House of Representatives
Session of 2017 - 2018 Regular Session

MEMORANDUM

Posted:	October 13, 2017 04:30 PM
From:	Representative Margo L. Davidson
To:	All House members
Subject:	Reasonable Gun Safety Legislation: Sending Mental Health Data to NICS and Firearm Background Checks

In the near future, I will be introducing legislation to require the transfer of all existing mental health data to the National Instant Criminal Background Check System (NICS), as well as permit the use of a single multi-day background check approval at gun shows across the Commonwealth.

While the debate on guns is a divisive issue, there are two areas that I believe both sides can agree on: 1) The reasonable dissemination of data by law enforcement to ensure those with mental health issues are unable to get their hands on a firearm; and 2) Enacting common sense gun reform that does not infringe on the rights of law-abiding gun owners.

Specifically, my legislation will require the Pennsylvania State Police to send all existing mental health data within 90 days to the National Instant Criminal Background Check System (NICS) and necessitate ongoing submissions to the national database within 72 hours of the State Police receiving mental health data.

In addition, my legislation will allow individuals to obtain a multiple-day background check approval to be used at a licensed gun show within the Commonwealth. Therefore, lawful gun owners would not have to pay for multiple background checks should they decide to purchase more than one firearm. Finally, my bill will require all firearm sales, regardless of barrel length, to be conducted in front of a licensed importer, manufacturer, dealer, or county sheriff, as the current provision is only applicable to short-barreled firearms.

In the wake of the deadliest mass shooting in our nation's history, it is not a moment too soon that we find bi-partisan common ground on legislation that respects an individual's right to own a firearm while simultaneously ensuring the safety of individuals across the Commonwealth from people with serious mental health issues and prohibited criminal histories.

Please join me in co-sponsoring this vital and timely legislation. Please email questions to whaigood@pahouse.net.

Thank you

House Democratic Policy Committee Hearing
Public Hearing with Representative Margo Davidson on
The Battle for Mental Health Treatment vs. Mass Incarceration
Testimony by Marilyn B. Benoit, MD, SHSA
Board Certified Child & Adolescent Psychiatrist and
Senior Vice President, Chief Medical/Chief Clinical Officer
Devereux Advanced Behavioral Health
November 27, 2017

- Address issue of BRAIN development and BRAIN Disorders vs. mental health.

- The entire country is now on the ACEs bandwagon. Adverse Childhood Events (ACE) refers to a landmark study by the Kaiser Permanente Foundation that revealed that childhood maltreatment, living in a negative family environment, having parents with mental illness and/or substance abuse and other negative environmental variables, correlate significantly with long-term illness and early mortality. Many states now have an ACEs consortium and are focusing on the reduction and prevention of ACEs. This is a major public health endeavor, never before attempted in the United States. Now that the impact of early trauma is being appreciated, human services departments across the country are mandating that Trauma Informed Care (TIC) be incorporated into organizations that provide services to their consumers.

- We cannot address incarceration issues without mentioning that the Federal Department of Health & Human Services has a nationwide initiative addressing human trafficking. The Trafficking Victims Protection Act (TVPA) was included in the Violence Against Women Reauthorization Act of 2013. This issue has become a general media topic, with increasing recognition that youth have been incarcerated when they should really have been rescued. State and local governments are beginning to address this issue and treatment programs are emerging to provide the youth with the appropriate interventions, including the assistance of legal supports.

- Children, adolescents, and young adults with autism spectrum disorder remain in the advocacy limelight. There are often media reports of the inappropriate arrests and incarceration of youth on the spectrum. There is a tremendous need for the police to be trained to recognize and understand individuals with autism who have serious communication and social challenges and whose behaviors can be mis-interpreted. Transitional services for those individuals entering adulthood are especially needed.

[MORE ON BACK]

- Assertive Community Treatment is designed to enable consumers to have accessible mental health treatment within their communities where their functional capacities can be enhanced with supports (e.g. recreational, employment, religious, spiritual, socialization) within those same communities.

- The unfortunate escalation of mass shooting tragedies across the nation is having an impact on the conversation at the state and federal levels about mental illness, and the dearth of services to meet the needs. Hopefully, there will be some monies released to address those needs.

- The Juvenile Justice sector needs to more vigorously address the mental health and educational needs of the youngsters who are adjudicated. Another area to be aggressively addressed is that of adolescent substance abuse. The opioid epidemic in our country highlights this grave issue. The unfortunate truth is that most adolescents start using opioids in their homes.... getting the drugs from their parent's medicine cabinets!

- In summary, we need to keep in mind that all the issues identified above involve BRAIN functioning. WE MUST recognize the critical importance of BRAIN health and provide the necessary interventions to support healthy BRAIN growth, and in cases where there are BRAIN disorders, then provide the appropriate rehabilitation. We do that for heart disease.... let's do the same for BRAIN disease.

Testimony
"A Public Crisis—The Battle for Mental Health Treatment vs. Mass Incarceration"
Yeadon Borough Hall, Council Room, 3rd Floor, 600 Church Lane, Yeadon, PA 19050
November 27, 2017

Submitted by:
Susan Rogers, Director of Special Projects/Advocacy
Mental Health Partnerships, 1211 Chestnut Street, 11th Floor, Philadelphia, PA 19107
srogers@mhphope.org, 267.507.3812

Thank you, everyone, for the opportunity to speak to you today. My name is Susan Rogers, and I am Director of Special Projects in the Advocacy Division of Mental Health Partnerships, a Philadelphia-based nonprofit advocacy and service organization serving local, regional, statewide, and national constituencies.

I have lived experience of a mental health condition and have been treated both voluntarily and involuntarily, locked up on a psych ward more than once and force-drugged. I have been in recovery for many years, and I know that recovery is real and possible for everyone.

I would like to cover three topics this afternoon:

- The highly exaggerated link between mental health conditions and violence,
- The programs and services that could help people with mental health conditions avoid incarceration and reduce recidivism, and
- Representative Davidson's proposed legislation.

I have provided Jim Dawes, Executive Director of the House Democratic Policy Committee, with a PDF of this testimony, which includes links to more information. I hope he will share that with you electronically.

First, it is wrong to conflate mental health conditions (also called mental illnesses) and violence. Only 3 percent to 5 percent of the violence in the U.S. can be attributed to people with mental health conditions. So, even if everyone with a mental health condition were deported, that would mean that 95 percent to 98 percent of the violence in the U.S. would still occur.

Did you know that, according to the Brady Campaign to Prevent Gun Violence, "…the U.S. firearm homicide rate is 20 times higher than the combined rates of 22 countries that are our peers in wealth and population"? "…[A]round the world other countries also have people with unmet mental-health needs. And yet among 171 nations of the world, the United States is the clear leader in mass shootings. It's the guns. Of course it's the guns."

And we could do better! For example, "[i]n 1996, after a mass shooting, Australia enacted strict gun laws. It hasn't had a mass shooting since."

Second, I am sure we all agree that people with mental health conditions are disproportionately represented in jails and prisons. And they do not fare well in the criminal justice system.

So what can we do about this? I'd like to mention a number of solutions:

1. **First, we need to address the social determinants of mental health.** According to the World Health Organization, "A person's mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age. Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities."

2. Next, **Crisis Intervention Teams**—in which a trained volunteer cadre of officers, from a fifth to a quarter of the Uniformed Patrol Division, take the lead in situations that involve individuals with mental health conditions—can divert people into treatment before they are booked. It is a partnership between law enforcement and the behavioral health system.

3. **Mental Health Courts can also keep people from becoming involved in the criminal justice system.** To quote from an NPR article: "[People] who are arrested and complete the mental health court program have a much lower recidivism rate than their peers: 20 percent versus 72 percent. 'The key is to identify people and get them treatment earlier,'" says Judge Steve Leifman in Miami-Dade County, Florida.

   In 2012, the Urban Institute released an evaluation, *Criminal Justice Interventions for Offenders With Mental Illness,* that showed that participants in two New York City mental health courts are significantly less likely to re-offend than similar offenders whose cases are handled in the traditional court system.

   There are Mental Health Courts in Delaware County, Philadephia, Montgomery, and Chester counties in southeastern Pennsylvania, as well as more than a dozen other Pennsylvania counties. According to the Delaware County DA's website, "The Court prefers to address non-violent offenses but other crimes will be taken into consideration on a case-by-case basis."

4. **Peer support** for individuals in prison and jail returning to the community addresses recidivism. Mental Health Partnerships just received a federal grant to bring peer support services to women and those who identify as female while locked up in Philadelphia's Riverside Correctional Facility (RCF) and as they transition to community upon release. The project, called Bridges to Home, focuses on three intersecting experiences: gender; women who have been identified as experiencing serious mental/emotional/psychological distress, substance/alcohol abuse, and/or these two challenges simultaneously; and women who have historically been homeless or who will be facing homelessness.

   The goal is to provide intensive services to between 25 and 30 women each year of the grant by training women who are incarcerated to become Certified Peer Specialists (CPS), and establishing a CPS program within the facility. Women who are 60 to 90 days out from release will be linked with MHP Case Managers and CPSs who will support the women as they navigate through a variety of services shown to improve community connection and reintegration by increasing the possibility of finding stable housing.

There are also a number of peer-run services in Pennsylvania that serve people with mental health conditions and criminal justice involvement.

5. **Restorative justice** emphasizes repairing the harm caused by criminal behavior. It involves identifying and taking steps to repair harm, involving all stakeholders, and transforming the traditional relationship between communities and their governments in responding to crime. The Pennsylvania Juvenile Justice System has adopted this model.

6. Because there is an overlap between people who have mental health conditions and people who have substance use disorders, I would like to add **harm reduction** as another solution. It is "a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence, to meet drug users 'where they're at,' addressing conditions of use along with the use itself."

7. The **elimination of cash bail** would also help keep people with mental health conditions, who often live in poverty, out of jail. This movement is trending: New Jersey has already eliminated most cash bail. Harris County, Texas, the third most populous county in the U.S., has also understood the unfairness of keeping people locked up simply because they are too poor to afford bail. And Philadelphia's newly elected District Attorney, Larry Krasner, has said, "The ideal situation would be to eliminate cash bail entirely."

8. **We also need a complete overhaul of the criminal justice system**. For example, North Dakota is adopting the Norwegian prison model, which is based on restorative justice and rehabilitation rather than punishment. To quote from an article in *Mother Jones*, "a growing number of state corrections officials are coming to the realization that our approach is ineffective, costly, and cruel. Fred Patrick, director of the Center on Sentencing and Corrections at the Vera Institute of Justice, cites the nation's staggering recidivism rate—77 percent of inmates released from state prisons are rearrested within five years. "Once you realize that this system isn't working well," he says, "it's fairly easy to pivot to: 'How do we do something different?'" North Dakota prisons chief Leann Bertsch is quoted in the article as saying, "How did we think it was okay to put human beings in cagelike settings?"

Finally, in regard to Rep. Davidson's proposed legislation, I would like to focus on just her proposal "to require the transfer of all existing mental health data to the National Instant Criminal Background Check System (NICS), as well as permit the use of a single multi-day background check approval at gun shows across the Commonwealth."

I would refer you back to the fact that the contribution to public safety of laws that restrict firearm access of people with mental health conditions "is likely to be small because only 3 [percent] to 5 percent of violent acts are attributable to serious mental [health conditions], ***and most do not involve guns"*** **(emphasis added).** "Pointing the finger at people with mental [health conditions] as the cause of the problem of violence in this country is misleading, counterproductive, and just plain mean." At the risk of being redundant, I want to say that "[t]he only variable that can explain the high rate of mass shootings in America is its astronomical number of guns."

I am grateful for the opportunity to talk with you today and am happy to answer questions. Thank you very much.

Significant Achievement Awards

The Nathaniel Project—An Effective Alternative to Incarceration

People with mental illness who are incarcerated receive limited—and in many cases inappropriate—psychiatric care. Frequently, their illness sets them apart from other inmates and makes them particularly vulnerable to violence and abuse. When released from jail or prison, these individuals tend to be denied access to housing and treatment in the community, because they are viewed as potentially disruptive to service systems. As a result, they are often caught up in a cycle of arrest, incarceration, release, and reincarceration.

The Nathaniel Project, a relatively young program that became fully operational in November 1999, is an alternative-to-incarceration program for people with serious mental illness who are charged with felony offenses in New York City. Named for a homeless man with schizophrenia whose illness went untreated during some 15 years of repeated incarcerations, the Nathaniel Project is a program of the Center for Alternative Sentencing and Employment Services (CASES), New York City's oldest and largest alternative-to-incarceration agency. The Nathaniel Project aims to stabilize offenders with serious mental illness in the community by providing treatment through the health care system rather than punishment through the criminal justice system. It offers intensive case management and court advocacy, links participants to mental health treatment and housing, and monitors participants' engagement with community-based treatment and rehabilitative service providers. By demonstrating that its clients can succeed in the community, can engage in treatment, and can lead law-abiding lives, the program helps participants build a new track record.

To participate in the Nathaniel Project, clients must both be prison bound and have an axis I diagnosis. Clients typically have had little or no treatment experience, have chosen to leave treatment in the past, and enter the program with little hope that treatment will help them. They tend to be homeless and suffer from co-occurring substance use disorders along with a host of related chronic medical conditions, such as AIDS, heart problems, hypertension, and asthma.

Potential clients are referred to the Nathaniel Project before final sentencing by lawyers or judges who suspect a psychiatric problem. Staff often begin an intake with no information other than that provided during the telephone call from the lawyer or judge. After the intake assessment, the individual enters treatment for a two-year period, and sentencing is deferred pending the outcome of treatment. In most cases, the treatment plan involves a supervised residential program. Regular reports must be made to the courts in order for a case to be adjudicated without the client's serving jail time. Clients who do not meet their treatment plan goals may be subject to arrest and incarceration.

Over the past two and a half years, the Nathaniel Project has served 53 individuals. The project's staff work with participants to overcome negative perceptions of mental health treatment by emphasizing that it is only through a commitment to treatment that they will avoid further contact with the criminal justice system. The project helps participants to see the connection between their symptoms and their offending behavior and, in turn, the connection between psychiatric treatment and reduction of symptoms.

Staff accompany participants to their mental health appointments and during family visits or interviews and provide practical advice and direct treatment as needed to ensure continuity of care during the transition to new providers. Staff members also teach basic community living skills, such as money management, and provide participants with a subsistence allowance for medications and basic needs such as clothing, food, and temporary housing to cover any gaps in benefits.

The consulting psychiatrist is an integral member of the project's staff. He has expertise in working with high-risk populations with criminal histories and is available 24 hours a day, seven days a week. The team also includes four forensic clinical coordinators, each of whom is a master's-level professional in mental health and psychiatric rehabilitation and carries a caseload of ten to 12 clients at any given time. The clinical coordinators are supervised by the project's deputy director, who holds a master's degree in social work and who is responsible for reviewing and approving all court reports and for securing participants' access to a variety of community-based treatments and services.

To supplement the efforts of the staff, it is envisioned that participants who complete the program will serve as mentors to clients who are new to the program. Thus consumers are directly involved in their own care, and the development of the program incorporates their experience.

The project has a number of quality assurance measures in place, including soliciting and documenting the judiciary's impression of the program's effectiveness, referring participants only to practitioners who are licensed and experienced, and regularly overseeing participants' care. Quality improvement is measured by

tracking the success of individual participants in terms of factors such as the participant's reconnection with the psychiatric treatment provider, access to housing, and reintegration into the community.

Locating appropriate treatment services in the community has been a challenge, both because of a general lack of services—particularly residential ones—in New York City and because of the resistance many providers express toward working with clients who have serious involvement with the criminal justice system or histories of violence. Funding and a lack of housing also present ongoing challenges, particularly given that this is a program in which 92 percent of participants are homeless at intake. The program has a good history of getting its clients into housing: so far 94 percent of its clients have been placed in short-term housing at the time of release, and 79 percent have been placed in long-term supportive housing after a year. The project has secured funding to develop its own supervised transitional housing, which is scheduled to open in 2005.

The project has had tremendous success in retaining participants: 98 percent of enrollees at 30 days after intake, 91 percent at four months, and 85 percent at 12 months, with an overall retention rate of 81 percent. Participants in the Nathaniel Project demonstrate a dramatic decrease in arrest rates. The number of arrests dropped from 101 (35 misdemeanor and 66 felony) in the year before entry into the program, including the arrest that brought them to the program, to seven (five misdemeanor and two felony) in the year since intake. All participants are currently engaged in mental health and substance abuse treatment programs, and all are receiving benefits such as Medicaid or Supplemental Security Income. The project has demonstrated that the yearly cost of providing services to a participant ($14,578) is significantly less than the cost of a year in a state prison ($29,678) or a city jail ($53,224).

The project has played an important role in promoting a dialogue between the criminal justice system and the mental health system—creating a dynamic and fluid connection between two systems that have not traditionally worked in partnership. The project's staff has had to confront the criminal justice system's widely held perception that mental health treatment is a "soft" and inadequate alternative to traditional incarceration. The courts trust the Nathaniel Project to monitor and supervise participants in the community, which is an indicator of their appreciation of the strong positive relationship between the provision of mental health treatment and public safety.

The project has received funding support from both mental health funders and criminal justice agencies. Funding for the Nathaniel Project for fiscal year 2001 came from the New York City Council ($300,000), Van Ameringen Foundation ($100,000 as part of a three-year grant), the New York Community Trust ($100,000 as part of a two-year grant), United Way ($75,000), the Frances L. and Edwin L. Cummings Memorial Fund ($50,000 as part of a three-year grant), and the Schnurmacker Foundation ($15,000). The project was recently awarded funding from the New York State Division of Probation and Correctional Alternatives.

The Nathaniel Project has served as a best-practices model at the national level for other jurisdictions and policy makers who are confronting the problem of how to serve mentally ill offenders. The project has been awarded the 2002 American Probation and Parole Association's President's Award and the Thomas M. Wernert Award for Innovation in Community Behavioral Healthcare. CASES staff served on the mental health advisory board for the Mental Health and Criminal Justice Consensus Project, a national initiative sponsored by the Council of State Governments. The New York State Department of Probation and Correctional Alternatives has invited CASES to produce an instructional CD-ROM and video to train staff from the courts and the criminal justice system in the early identification of mental illness. In addition, mental health staff from the Bureau of Forensic Services presented the Nathaniel Project as a model program at a statewide best-practices conference in Brooklyn last year. Finally, the Bazelon Center for Mental Health Law has promoted the project as a best-practices model for serving people with mental illness in the criminal justice system.

By using an integrated approach that addresses the complex interaction of mental illness, substance use, and homelessness, the Nathaniel Project successfully balances the mental health needs of the individual on one hand and accountability to the court on the other.

For more information, contact Yves Ades, M.D., Director of Mental Health Programs, CASES, 346 Broadway, Third Floor, New York, New York 10013; phone 212-533-6314; fax 212-533-6300; e-mail, yades@cases.org; Internet, www.cases.org.

Testimony by Frankie Berger, Director of Advocacy

Treatment Advocacy Center

Before the House Democratic Policy Committee

To Discuss the Battle for Mental Health Treatment versus Mass Incarceration

November 27, 2017

Good afternoon Representative Davidson and the House Democratic Policy Committee. I appreciate the opportunity to testify today, and I applaud Representative Davidson's leadership on these important issues. My name is Frankie Berger, and I am the Director of Advocacy for the Treatment Advocacy Center based outside of Washington, DC. The Treatment Advocacy Center is a policy, legislative, and research non-profit and we partner with residents in all states and the federal government to remove legal and policy barriers to the treatment of severe mental illness. We never accept funding from companies or entities involved in the sale, marketing or distribution of pharmaceutical products.

I will focus my discussion today on the relationship between untreated serious mental illness, decompensation, the resulting excessive rates of criminal justice involvement for this population, and the law and processes in place that perpetuate this cycle in Pennsylvania. I will also highlight a few practical, evidence-based solutions the legislature may decide to implement that would have real world benefits to individuals with serious mental illness and the public systems that serve them, as well as bring cost savings to the Commonwealth.

Less than 4% of the population has a serious mental illness. But they are disproportionately represented in our criminal justice system. Right now, if you have a mental illness in Pennsylvania you are twice as likely to be incarcerated as you are to receive treatment. Pennsylvania has about 331,000 individuals living with a severe mental illness that disorders their thinking. On any given day, about half - 165,500 - of them are not taking medication or receiving any other care. People with untreated serious mental illness account for 1 in 4 of all fatal police encounters, 1 in 5 of all jail and prison inmates, and 1 in 10 of all law enforcement encounters.

A major factor contributing to untreated mental illness is anosognosia. Different than denial, anosognosia is a clinical lack of insight into one's illness, which makes taking medication, volunteering for and seeking out services illogical and exceedingly difficult for the affected individual. As a symptom of their illness, 50 percent of people with schizophrenia and 40 percent of people with severe bipolar disorder do not recognize that they are sick and in need of treatment.

Another major contributing factor is that the Pennsylvania Mental Health Procedures Act (MHPA), which has not substantively changed since 1976, requires a person to be a "clear and present danger" to themselves before they can receive involuntary care. This standard - the most restrictive in the country - is the same both for inpatient hospitalization and for outpatient treatment, and does not reflect modern standards adopted by almost all other states to create a path to treatment for people in less restrictive settings.

People with untreated mental illness are high utilizers of public services, and are typically well known in the public systems. They cycle in and out of the revolving door of untreated illness, hospitalizations, arrests, incarcerations, homelessness, violence and victimization. Access to treatment, in a variety of forms, is necessary to break the cycle and reduce criminalization.

However, the Pennsylvania behavioral health system is currently set up to treat only those 50 percent who can voluntarily seek and participate in services, unless they meet the MHPA's "clear and present danger" standard. This is a recipe for over-incarceration of serious mental illness.

As stated by the Pennsylvania Association of County Administrators of Mental Health and Developmental Services in their 2016 Pennsylvania's Mental Health Procedures Act White Paper, "as the current process essentially requires people with a serious mental illness to become dangerous before we can support them, the practical effect is to criminalize mental illness."

A practical solution is to update MHPA civil commitment criteria to include a separate path for community based treatment and recovery through creating an Assisted Outpatient Treatment (AOT) procedure. There is outstanding evidence across diverse states and jurisdictions that a functional AOT law can play an essential role in the behavioral health system by providing a route to earlier intervention *before* people become dangerous.

According to the American Psychiatric Association, "For the vast majority of individuals with mental illness, court-ordered treatment will never be a needed aspect of care. For a subset of the most severely and persistently ill, outpatient commitment (also known as Assisted Outpatient Treatment) is an effective tool that, if properly implemented, can promote treatment adherence, keep individuals in more supportive community environments, prevent repeated emergency hospitalization or incarceration, reduce homelessness, and decrease the potential for violence to self or others."

AOT is a civil, non-punitive court process – participants cannot be held in contempt, fined, or jailed for failing to comply.

AOT enables mental health professionals to intervene earlier to stabilize and prevent further deterioration in the person's condition, helping to prevent the need for more costly intervention down the road. Generally, from a cost perspective, it is not a question of whether intervention will occur, but rather when and how this intervention will take place. The experience in other states utilizing AOT indicates that intervening sooner with this population, and using community-based interventions, prevents human suffering as well as a more effective use of public resources. This saves money in the mental health system, the acute care system and criminal justice system.

States and counties with effective AOT programs have seen drastic reductions in arrests, incarcerations, and days incarcerated. They have also seen drastic reductions in hospitalizations and lengths of stay. In New York, where every county in the state has an AOT program, state level data for participants in AOT showed 77% fewer experienced psychiatric hospitalizations with 56% reduction in length of stay, 83% fewer experienced arrest, 87% fewer experienced incarceration, 74% fewer participants experienced

homelessness, 55% fewer engaged in self harm, 47% fewer harmed others, and 75% of participants said AOT helped them gain control over their lives. This year, in Orange County California, county level data for participants in AOT shows a 70% decrease in hospitalization days, 72% decrease in hospitalization episodes, 75% decrease in incarceration days, and 56% decrease in incarceration episodes. And through treatment, we reduce both victimization and violence.

AOT has been a federally sanctioned evidence-based program for years (SAMHSA National Registry of Evidence Based Programs and Practices, DOJ National Institute of Justice), and is now funded in two ways through the 2016 CURES Act, which provides SAMHSA grant funding streams and technical assistance to states and local jurisdictions who want to establish an AOT program. Additionally, states with functioning AOT laws can now use DOJ grants for AOT in civil courts as an "alternative to incarceration" that provides treatment opportunities before the need for criminal justice involvement.

The legislature should also consider exploring the many unrealized opportunities for criminal justice reinvestment at the local level. While they are stuck in the revolving door, Pennsylvanians with untreated serious mental illness are high public service utilizers across systems, including behavioral health, emergency department care, hospital care, homelessness services, emergency services, law enforcement services, and corrections.

Many individuals are "shared" between these systems that are artificially separated through department budgets. By recognizing that treating serious mental illness reduces law enforcement and incarceration costs and that treatment access spans multiple systems, there may be opportunities for the criminal justice system to collaborate with the behavioral health system to invest a portion of criminal justice savings into mental health services targeted specifically to treat those with the most serious illnesses.

While these measures are fundamentally important for adults with chronic histories of interaction with mental health providers and law enforcement, equally important are measures to remove barriers to treatment for first time psychosis. These illnesses often present themselves in older adolescents and

young adults, and mental illness is the leading cause of disability in the US. Early intervention and access to care are essential, and we are working with Representative Davidson on legislation to help enhance access to appropriate and timely treatment.

When structured with high fidelity to the model, Assertive Community Treatment (ACT) teams are considered the gold standard for providing critical wrap-around services in the community to people with serious mental illness. Representative Davidson is working on significant legislation to professionalize and expand ACT teams in Pennsylvania counties, as well as to provide avenues for privately insured individuals who require ACT level of care and their families to access appropriate services if they do not qualify for Medicaid.

Another barrier to treatment is misunderstanding of what information can be shared under HIPAA privacy laws. Representative Davidson is also working to address some of these issues. This legislature may consider pursuing clarification in the statue and/or better education of providers around the flexibility in HIPAA and guidance that allows sharing of vital information with families and caregivers in certain emergencies. Providers and facility administrators are oftentimes afraid to share vital diagnosis and treatment information with caregivers for fear of legal action for violating HIPAA, effectively shutting families out of care.

Other things the Pennsylvania Legislature may consider to help address this issue on the front end:

- Pass a law that allows counties to use assisted outpatient treatment – a civil, not criminal, court process that requires people with serious mental illness and a history of bad outcomes from treatment noncompliance to follow a treatment plan in the community. This reduces costs in the criminal justice and health systems, and significantly reduces arrests, incarcerations, hospitalizations, homelessness, victimization and violence. We thank you all for your leadership in passing HB 1233 out of the House. The legislation seeks to provide a new set of criteria and clear processes and procedures for AOT. It is a fundamental step toward providing this

important avenue for care for vulnerable Pennsylvania citizens, but it is not yet done, and we request your continuing support as the bill moves forward through the legislature.

- Consider updating your inpatient civil commitment laws. Currently, Pennsylvania by law requires someone to be clearly and presently dangerous before they can receive help. We also have a criminal justice system that arrests people who are clearly and presently dangerous. This is an impossible needle to thread for families who are forced to wait until their loved ones are just dangerous enough to warrant police involvement, but not dangerous enough to truly harm themselves or their families.
- Increase access and the number of hospital beds for acute and chronic psychiatric treatment. A good ratio of accessible, appropriate inpatient beds to population makes it possible to have more effective outpatient programs, because people are generally more stable when coming out of hospitalization.
    - There is an extreme lack of available beds for both civil and forensic patients. Reductions in forensic bed wait times is often due to states having legislated their way out of a waitlist by diverting civil beds to be used for forensic services. Jails and prisons are routinely used to board people with mental illness, as are hospital emergency departments.
    - Apply for a Medicaid 1115 waiver to allow federal reimbursement for adult inpatient psychiatric treatment. An antiquated law currently prohibits that reimbursement, but Pennsylvania has neglected to pursue the avenue out of it, even though it is an option available now to states. Fortunately, the Department of Human Services is currentlty considering an 1115 Waiver in this area.
    - Explore community competency restoration. Forensic beds are often used for restoration to competency, a process that could be done outpatient for many low-level nonviolent offenders. Moreover, the purpose of competency restoration is not therapeutic treatment, but a process undertaken for the benefit of the court to restore an individual to a mental state in which they can understand and face their charges.

- Ensure people have a path to services on reentry into the community following incarceration.
- Explore bail reform measures that screen for risk and consider mental illness diversion pre-arraignment.

Ultimately, you all are tasked with making tough decisions to get treatment to people who need it the most. One way is to create pathways that require targeted funding towards the most expensive, most vulnerable, untreated people with mental illness. No one but the legislature can effectively do that, and in the absence of legislation, treatment of those who are the most sick is largely ignored until the problem is so dire it necessitates hospitalization or incarceration.

A result is that providing care for people who are the most sick has been largely taken out of the hands of the behavioral health system and dropped into the lap of the criminal justice system. Corrections facilities are punitive and not therapeutic settings, and yet they are responsible for providing mental health treatment to more people than state hospitals. Jails are filling up with people with mental illness boarded there waiting for competency restoration beds. We are leaving it to state corrections systems to make important, life altering behavioral health treatment decisions they are unqualified to make, and often – as we have seen recently in Pennsylvania - under the duress of lawsuits and settlements. This is a situation that Secretary Wetzel has spoken out about repeated ly.

This has resulted in a battery of well-intentioned desperate acts that find states making laws to hold people in acute psychiatric crisis in jails for their own safety, or in solitary confinement for their own safety, engaging in “mercy arrests” as an avenue to treatment, and sending civilly committed men and women with no charges to a state prison because there are no secure psychiatric hospital facilities. We have created a system where parents are calling the police on their own children in hopes that it will provide a route to the treatment they have failed to receive through the mental health system. Ask yourselves for what other illness do we put people in jail for their safety?

If there are any available alternatives to explore, we should never require that someone fail, decompensate to the point of psychiatric crisis, or end up in jail in order to receive care. You all have many paths to consider, but all of these practical measures will challenge the unacceptable status quo. We need the legislature to make the case for treatment before crisis, and I urge you all to join Representative Davidson as champions for change.

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November 27, 2017

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Department of Human Services

Jonna L. DiStefano, M.A.
BH/ID Administrator

The need for housing the forensic population continues to be a high priority for the Delaware County Office of Behavioral Health. Individuals released from State Correctional Institutions or Delaware County Prisons with viable home plans are readily absorbed into the community with resources such as Medication Management, Outpatient, Case Management, Peer Support, etc. as primary support services. However, for those individuals without viable home plans, placements can be challenging to procure. Similar pressures exist with meeting the housing needs of persons in the SFTC or those in DCP awaiting competency restoration.

Delaware County continues to emphasize recovery and transition in its facility-based Community Residential Services (CRS) programs. County government is an integral partner with the Commonwealth in providing services and support to our mutual constituents, whether human services, criminal justice, environmental stewardship, economic development, or any of a range of other activities. As the emphasis shifts away from incarceration at the front door to helping individuals access treatment. The County is attempting to address this from a back door approach. We continue to provide Crisis Intervention Training (CIT) for police officers annually. This training provides the officers with best practices, interventions to better equip them in working with individuals that may be experiencing a mental health crisis and/or disorder. As a result, of these ongoing trainings, we currently have over 300 officers trained. In addition, the county has several specialty courts, which were been developed as a diversion to incarceration. Some of these specialty courts are Mental Health Treatment, Drug Treatment Court, and Second Chance to name a few. These diversionary courts are used to prevent incarceration and promote treatment and community tenure.

In an effort to address some of these challenging needs, the Delaware County Office of Behavioral Health in collaboration with several other stakeholders, community providers and systems have developed various community resources. The development of the Forensic ACT (FACT) program, which is one of the county's dedicated forensic resources which provides intensive treatment services to individuals released from the SCI's, DCP, and the SFTC. These assertive community teams (forensic-focus) are an intensive and highly integrated approach for community mental health service delivery. FACT programs serve individuals whose symptoms of mental illness has lead to serious functioning difficulties in several major areas of life, often including work, social relationships,

residential independence, money management, and physical health and wellness and involvement with the criminal justice system. This particular team works with the individual to promote healthy community living and reduce the rate of recidivism.

There has also been the development of the Residential Treatment Facility which is currently operating on the grounds of Norristown State Hospital. This is sub-acute care treatment program with variable lengths of stay. The RTF-A provides comprehensive programming incorporating multiple services designated to facilitate restoration to competency and management of behavioral health challenges. This is a sixteen bed program for individuals with criminal involvement, who may be in need of competency restoration and/or further stabilization. This has afforded individuals the opportunity to be released from prison to receive the treatment needed. This program has also been used as a diversion for some individuals living in the community that may have some contact with law enforcement.

Affordable, accessible quality housing remains an ongoing issue for many individuals within this population. As a result, this office working in collaboration with one of the correctional providers began discussions of the possibility of the development of a transitional housing program. The transitional housing program was developed within an existing DOC halfway CCC program. OBH working with this provider, developed an all-male, 9-person facility. This facility was available to those individuals maxing out of SCI and DCP facilities in need of housing options. Within this unique program, individuals were re-connected to mental health out-patient services, assistance with re-establishing MA benefits and employment and/or vocational options. As individuals transitioned back into their community and were re-connected to services and further stabilized other housing options were made available. Due to the success of this program, its capacity was recently increased and it is now serving a total of 21 individuals in which females are included.

We recognize the need for accessible, affordable quality housing as a barrier for this population as well. As funding allows, our office works with contracted providers for Supportive Living Services (SLS) in which Master Leasing subsidies are provided for this service. SLS offers individuals an opportunity to live independently in the community with supports. Recognizing the difficulties many incurs in finding housing due to their criminal history, the provider leases the units (Master Lease) and the individual pays their portion directly to the provider. This provides an opportunity for the participant to obtain a payment history and tenure within the current establishment. In many cases, within a few years, the proprietor, agrees to lease directly to the individual. Increasing the stock of Master Lease subsidies is an important and cost-effective tool in meeting the increased demand for forensic housing. The Forensic ACT (FACT) program, is one of the county's dedicated forensic resources which provides intensive treatment services to individuals released from the SCI's, DCP facilities This is consistent with OBH's ongoing plan to commit most new dollars to the least restrictive and most cost-effective, community-inclusive housing options.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS

Good Afternoon Representative Davidson. My name is Lynn Patrone. I am the Mental Health Advocate for the Pennsylvania Department of Corrections (DOC). Thank you for the opportunity to testify today. Prior to my position as the Mental Health Advocate for DOC, I served as the Chief of Staff for the Office of Mental Health & Substance Abuse Services within the Department of Human Services. Both of these positions provided me with the systemic firsthand experience of the adverse obstacles our re-entrants, living with Serious Mental Illness (SMI) encounter when returning to their communities.

Today, I would like to paint a picture of the increasing challenges, we, as advocates encounter when coordinating services. Our goal is to provide the foundation for successful re-entry. Too often the SMI population becomes lost in the criminal justice system, when, if such individuals had been provided with appropriate treatment, programs and supports within the community, criminal justice intervention might have been prevented. Many individuals are very ill, homeless or at risk of homelessness, and are without family and other natural supports. Too often, they recidivate and are returned to the penal system. In Pennsylvania, there are only 6 counties providing Forensic Assertive Community Treatment (FACT) services. Those counties are Beaver, Bucks, Philadelphia, Delaware and Luzerne/Wyoming. FACT is an evidenced based comprehensive approach to offering individuals an opportunity to become members of their community, rather than inmates of the penal system. Too often, individuals become housed in prisons because we lack adequate and appropriate levels of services within the community. Not only is addressing the underlying illness a prudent practice, it provides individuals with the opportunity to realize a quality life, an opportunity to become productive members of society and also reduces recidivism and undue financial burdens on county and state systems.

As we advance in mental health treatment and services, mental health professionals recognize the invaluable opportunity to support recovery for individuals through modern day treatment options such as FACT. Just as advances in physical health treatment changed the medical landscape from long term hospitalization to community based short term treatments, so too may we benefit from advances in mental health treatments. Many of the services of the 60's and 70's, such as partial hospitalization and traditional outpatient therapies simply do not meet the complex treatment needs for the SMI population. We can no longer, nor should we, rely solely on providing treatment in institutions, be it prisons or other institutional settings. But this is exactly what we are doing when we do not adequately provide opportunities for appropriate levels of treatment and the health care coverage to support such treatments. Treatment programs such as FACT serve a very vulnerable population and provide natural, clinical and peer supportive services to allow individuals with SMI to remain in the community in the least restrictive setting. Specifically, FACT is a comprehensive prevention, intervention and treatment program that provides wrap-around services to prevent a seriously mentally ill person from entering into institutionalized systems, such as the criminal justice system. FACT is an evidenced-based treatment and practice and provides the critical intervention to prevent individuals from entering into criminal justice systems.

It is imperative that modern treatments for the mentally ill include evidenced-based treatments. It is even more imperative that as advocates we challenge our government leaders to advocate for and support mental health services that include the holistic needs of the person, to include the essential basics that each of us enjoys, such as housing, vocational training, pro-social skills and natural supports.

As the DOC Mental Health Advocate I am faced with the seemingly impossible challenge to assist re-entrants in returning to their communities. The DOC houses about 4,500 individuals (9% of its population) who live with serious mental illness, many of whom will be returning to our communities as our neighbors. The challenges we encounter are daunting and despite innumerable efforts by various local and state agencies, too often we are unsuccessful in identifying adequate placement in the community. It is common practice for our social services staff to make hundreds of outreach contacts to social service and behavioral health agencies to no avail in an attempt to assist just one individual who has an SMI and is reentering the community. We are simply ill

equipped to meet the demand of the increasing SMI population from a correctional and reentry standpoint or to prevent an individual from initially entering the criminal justice system.

It's important to discuss the point of entry into the correctional system and diversions that can be implemented. We need to have an increase in Crisis Intervention Training (CIT) to local first responders and law enforcement, mental health courts and specialized crisis emergency services. If an individual is exhibiting symptoms of mental illness and encounters a law enforcement officer who does not have specialized training, the outcome can be very different than if that officer had been trained in CIT.

Many of the individuals we house with SMI were homeless prior to incarceration. Too often, individuals with mental illness exhibit symptoms of their illness that may lead to an arrest which may be diverted if front end interventions and access to treatments were readily available. We are facing a mental health crisis due to the limited number of state hospital beds. This evolution represents a time of change for Pennsylvania. I challenge each of us to consider that the individuals we are here to speak on behalf of today are our family members, neighbors and friends. It is very important that we remember to recognize that providing appropriate mental health services is paramount to ending the cycle of unnecessary institutionalization, particularly in a prison setting. Over the past 3 years the mental health population in the DOC has increased from 25% to 31%. The trajectory is trending upwards and without appropriate mechanisms to meet the needs of our families, friends and neighbors we face a community crisis that we, as leaders simply cannot ignore.

Programs such as FACT can provide the bridge to reducing the incarcerated population, providing quality effective services and most importantly offering an individual who is ill the opportunity to achieve hope and recovery and a chance at a quality life.

So Where Do We Go From Here: DOC releases individuals with serious mental illness every month that need housing, services, and other supports. We have a major shortage of placements for them and have particular issues when we encounter the Good Neighbor Rules around placement of those with certain crimes. Without increased programs that are available and

accessible, we hit brick walls and the likelihood for recidivism is very high. It is critical to implement and increase the use of the early interventions and diversionary programs mentioned earlier. It is our goal to offer the tools, skills, and recovery opportunities that will begin the journey of success for an individual being released so that they may achieve successful reintegration.

Thank you for the opportunity to speak with you today.

House Democratic Policy Committee – Mental Health Treatment in the Criminal Justice System

November 27, 2017

Pennsylvania Chiefs of Police Association
Scott Bohn, First Vice-President
Chief of Police, West Chester Borough Police Department

House members, staff, fellow witnesses, and concerned citizens, I wish to express our sincere appreciation for the opportunity to have the Pennsylvania Chiefs of Police Association provide input at today's important hearing. As you know, our organization represents over 1,000 police leaders in Pennsylvania and we consider ourselves to be the informed and respected voice of professional law enforcement in the Commonwealth. We are not a lobbying organization, but consider our role to be a resource for providing information regarding the impact of public policy and the tools needed for effective law enforcement.

As you know, law enforcement agencies across Pennsylvania have faced increasing demands in recent years on many fronts. The heightened need for diligence in addressing violent crime, property crime, domestic violence, child abuse, gang violence, sexual predators, and traffic enforcement are now compounded by our need to be prepared for terrorism, active shooters, violent public demonstrations, internet fraud, and the explosion of opioid related deaths and crime. Since 2014 there has been a dramatic increase in scrutiny of the police through "viral videos" and other sources. Critics of police use of force and a trend to demonize the police can be difficult while the police themselves have suffered increased assaults as evidenced just last week in New Kensington with the death of Officer Brian Shaw.

These increased demands are compounded by the clear reliance of the criminal justice system as the first point of contact in many situations impacted by mental health. It is well known that the prison population is saturated with inmates suffering from varying mental illnesses and that the prisons are the primary means of incapacitation for people with mental illness. As many as one-fourth of those killed in officer involved shootings are mentally ill or in emotional crisis according to the Washington Post. A study by the American Psychiatric Association showed that one department had over 10 percent of their officer shootings over a ten-year period attributable to suicide- by – cop.

As we see in our current laws, the mechanism for police officers is in place to institute involuntary commitment for evaluation and any police officer in Pennsylvania can tell you that they must use this authority all too frequently and that these situations are fraught with danger. We do find that many times it appears that these evaluations result in release of individuals who appear to pose a continuing danger to themselves and others. Community based treatment is also an area that continues to grow, and our officers also find that we must respond regularly to assist with patients who are in the community setting. In addition, there is the ongoing question of access to firearms by those who are mentally ill, and the dangers presented in those cases.

In addition to legislative remedies, law enforcement and our mental health treatment partners throughout Pennsylvania have seen that two of the most promising programs for law enforcement are The Crisis Intervention Team (CIT) approach and Mental Health First Aid (MHFA) training. CIT is a 40-

hour training that allows for officers to provide crisis intervention and focus on de-escalation, diversion and treatment in partnership with mental health treatment service providers. Mental Health First Aid (MHFA) is an eight-hour course focused on mental illnesses and de-escalating incidents without compromising safety. According to statistics from the Pennsylvania Commission on Crime and Delinquency (PCCD), over 6,000 Pennsylvania police officers have received either CIT or MHFA training. Every year, PCCD, in collaboration with the Office of Mental Health and Substance Abuse Services and Centre County CIT hold a Statewide Crisis Intervention Team Meeting. The 2017 meeting included a Train-the Trainer Workshop on Verbal De-Escalation. The 2018 meeting will be held in State College on March 20th and 21st.

We see these as a few of the improvements that can be made from the law enforcement perspective. The International Association of Chiefs of Police (IACP) instituted an initiative in 2016 called the One Mind Campaign. **The One Mind Campaign seeks to ensure successful interactions between police officers and persons affected by mental illness.** The initiative focuses on united local communities, public safety organizations, and mental health organizations so that the three become "of one mind." To join the campaign, law enforcement agencies must pledge to implement four promising practices over a 12-36-month time frame.

These practices include: establishing a clearly defined and sustainable partnership with a community mental health organization, developing a model policy to implement police response to persons affected by mental illness, training and certifying sworn officers and selected non-sworn staff in mental health first aid training, and providing crisis intervention team training.

We believe that the police have been relied on in many ways as the primary contact with those suffering mental illness and that those efforts mentioned above as well as the need for advanced and available treatment are critical to deal with this important issue.

We are happy to provide additional resources or answer any questions which you may pose or submit.

Statement Submitted for Record by Dr. Kirk Heilbrun of Drexel University

Please consider the following statement of support for Representative Davidson's bills:

> The limitation on community treatment resources for severely mentally ill citizens is a huge problem for these individuals, their families, and the larger communities to which they belong. With ever-shrinking bed space available in state psychiatric hospitals—or with existing beds devoted to the treatment of individuals involved with the criminal justice system—the comprehensive treatment resources available to some of our most vulnerable citizens and their families are inadequate.
>
> I strongly support Representative Davidson's bills, for two reasons. First, their adoption would increase the treatment resources available to seriously mentally ill individuals in the community. Second, they do so using an approach (Assertive Community Treatment, or ACT) that has strong empirical support for its effectiveness and efficiency. This would be a very good use of taxpayer dollars, improving the lives of individuals, families, and communities.

Thank you.

Kirk Heilbrun, Ph.D.
Professor
Department of Psychology
Drexel University

Written Testimony on Mental Health Treatment in the Criminal Justice System

Office of Mental Health and Substance Abuse Services

Pennsylvania Department of Human Services

House Democratic Policy Committee Hearing

November 27, 2017

Thank you for the opportunity to submit written testimony about access to publicly funded mental health, forensic mental health services in Pennsylvania, and the Pennsylvania Department of Human Services' (DHS) interaction with individuals in the criminal justice system.

The Office of Mental Health and Substance Abuse Services (OMHSAS) within DHS has responsibility for the management of the HealthChoices Behavioral Health Managed Care Program within DHS. OMHSAS works in partnership with counties and Behavioral Health Managed Care Organizations (BH-MCOs) to support local treatment and recovery-oriented supportive services for over 650,000 Pennsylvania residents each year.

OMHSAS oversees the provision of behavioral health services throughout the commonwealth and is responsible for administering the federal Mental Health State Block Grant funds and other state appropriations to the local county Mental Health Programs. OMHSAS' projected spending for fiscal year 2017-2018 exceeds $4.8 billion in state and federal dollars to support positive behavioral health.

The HealthChoices Behavioral Health Managed Care program, which was built in partnership with our local county governments, ensures mental health and substance use disorder (SUD) services to eligible Pennsylvanians. There are three goals for the program: to assure greater access to services by unifying service development and financial resources at the local level closest to the people served, to improve quality, and to manage costs. In 2015, Governor Tom Wolf expanded Medicaid in Pennsylvania to all individuals below 138 percent of the federal poverty level. As of July 2017, 2.6 million people were enrolled in HealthChoices Behavioral Health.

We know that people with behavioral health disorders can and do recover. OMHSAS is committed to ensuring that individuals served by the mental health and SUD service system have the opportunity for growth, recovery, and inclusion in our communities; have access to culturally competent services and supports of their choice; and, enjoy a quality of life that includes family members and friends. OMHSAS' guiding principles are to provide quality services and supports that facilitate recovery for adults, including older adults, and resiliency for children; emphasize prevention and early intervention; and, ensure collaboration with stakeholders, community agencies, and county service systems.

Community-Based Mental Health Services

DHS provides supports for an array of community-based services that build on natural and community supports unique to each individual and family. The Mental Health/Intellectual Disability Act of 1966 describes the state and county responsibilities related to mental health services in Pennsylvania. Counties are responsible to ensure that the following mental health services are available to citizens in their counties or joinders: inpatient hospital services, outpatient services, partial hospitalization services, emergency services 24/7, centralized intake and referral processes, and aftercare for individuals released from state or county facilities.

Individuals can contact the local county mental health program office for assistance in accessing mental health services. County mental health programs determine eligibility for service funding, assess the need for treatment and other support services, and make referrals to appropriate services in the community. The majority of mental health services are delivered by licensed provider agencies under contract with the county mental health program. County mental health

program offices use base funds to pay for services for priority populations, which are individuals with a serious mental illness or children with serious emotional disturbance, who are underinsured or uninsured.

State Mental Health Hospitals and Long-Term Restoration Center
Pennsylvania operates six mental health hospitals and one restoration center. As of July 28, 2017, there are 1,479 people being served in our state hospitals and restoration center.

The primary purpose of the state hospital system is to provide high-quality inpatient treatment to persons committed under the Mental Health Procedures Act so that the individuals served develop the skills, resources, and supports needed for recovery and are able to return to the community. The South Mountain Restoration Center provides licensed skilled nursing and intermediate long-term care services to older adults with special needs whose needs cannot be met by other community nursing facilities.

Due to state hospital closures, the Community Hospital Integration Projects Program (CHIPP), and our commitment to complying with the Supreme Court's Olmstead decision, in which the Court held that public entities must provide community-based services to persons with disabilities when possible, our census has decreased from 2,928 patients to 1,479 since the year 2000. CHIPP creates services to support persons with a long-term history of hospitalization or other complex needs so that they can live successfully in the community. CHIPP funds are used to pay for services and supports that are not Medicaid eligible, such as housing and non-clinical support services, or for services for people who are not Medicaid eligible through a unified systems approach. Behavioral Health HealthChoices and CHIPP also include funding for diversionary services for people who may be at risk of state hospital admission.

Pennsylvania's Forensic Mental Health Service System
Pennsylvania's forensic mental health units serve adults over age 18 and juveniles adjudicated as adults who have a mental illness and who are involved with the criminal justice system. Forensic services are psychiatric services that help stabilize individuals who have been arrested so that they can return to their referring jurisdictions to participate in pending criminal proceedings.

A person is deemed incompetent to stand trial if, due to a mental illness, they are substantially unable to understand the nature or object of the proceedings or to participate or assist in their defense. Not everyone with mental illness is automatically considered incompetent to stand trial. Competency restoration is the provision of mental health treatment, including medication and therapy, to restore competence to stand trial.

DHS operates two regional psychiatric forensic centers at Norristown and Torrance for these individuals and also provides extended care for individuals who have not responded to treatment and are not able to participate in their own defense. Other individuals are in these facilities in extended care because of a judicial determination that they are not guilty for reason of insanity.

DHS works to promote models and interventions that minimize interactions with the criminal justice system, while connecting individuals to appropriate services regardless of when and where they present. OMHSAS works with key stakeholders to improve treatment approaches, community-based residential treatment and housing options, and other supports to more fully meet the needs of individuals with behavioral health concerns that are involved in the forensic

service system. DHS will continue to expand and improve the continuum of treatment services and alternative placements for individuals referred to the DHS forensic service system; improve active care management for men and women in the forensic system; improve care for individuals who are clinically appropriate for forensic restoration services; and, develop alternate treatment pathways for individuals with other clinical needs.

Individuals with Mental Illness in State Prisons or County Jails

OMSHAS provides a wide variety of services to keep people with serious mental illness in their communities and out of prison. Due to these efforts, an estimated 92 percent of Pennsylvanian's with serious mental illness avoid incarceration. For those that do become involved in the criminal justice system, however, OMHSAS is committed to ensuring access to culturally competent, recovery-oriented, quality services and supports.

An individual 18 years or older can be diagnosed with serious mental illness (SMI) if he or she has, at any time during the past year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in functional impairment which substantially interferes with or limits one or more major life activities. The presence of an SMI does not typically lead to criminal behavior unless it is coupled with a co-occurring substance use disorder (COD). Nationally, approximately 80 percent of incarcerated individuals with serious mental illness have a COD. An estimated 72 percent of individuals with mental illness in county jails have co-occurring substance use disorders. These individuals have unique and complex emotional, behavioral, and social needs that create challenges for families, service agencies, and community supports.

Individuals with CODs are at comparatively high risk for incarceration because the destabilizing effects of two sets of interacting disorders result in behavioral disturbances, cognitive impairment, and the commission of crimes, arrest and subsequent sentencing. In addition, these individuals are more likely to experience other criminogenic risk factors, such as prior victimization, homelessness, and limited access to health care.

Failure to accurately identify individuals with CODs often prevents their involvement in treatment and leads to inappropriate placement in treatment. This results in comparatively high rates of criminal recidivism following release from custody – with an estimated 68 percent of people with CODs having at least one readmission to jail within four years of release – and utilization of expensive community resources such as crisis care and hospital beds.

DHS works in concert with the Department of Corrections (DOC), the Commission on Crime and Delinquency (PCCD), the Department of Drug and Alcohol Programs (DDAP), counties, and other state entities and local partners to identify individuals with SMI wherever they might present within the criminal justice continuum. After identification, we work to provide treatment and supports throughout the justice continuum and upon return to the community.

There are five common factors that affect treatment and transition planning for individuals with SMI who are also involved in the criminal justice system that are returning to the community following sentences in state prison or a county jail. These factors are:

1. **Access to health care benefits upon discharge from prison or jail.**

The jail population has high physical and behavioral needs but faces substantial barriers to accessing health care. These challenges are exacerbated by the low rate of health insurance coverage among incarcerated individuals. Addressing complex behavioral health needs post-release has been shown to reduce recidivism and improve public health and safety.

Prior to the Affordable Care Act (ACA), few among Pennsylvania's jail population were eligible for public health insurance. This population also has limited access to employer- or school-based health insurance. The few who were enrolled often lost coverage when they entered the corrections system. Nationally, an estimated 35 percent of those newly eligible for Medicaid are individuals who have been involved with the criminal justice system, largely due to relatively low incomes and low insurance rates. Pennsylvania's implementation of ACA, including the Medicaid expansion initiated in 2015, has extended eligibility and enhanced access to health care coverage for the jail population.

In 2016, the DHS debuted a shortened Medicaid application and expedited processing time available for inmates as they leave a State Correctional Institution (SCI), Community Corrections Center (CCC), or county jail. The change to suspend rather than terminate Medicaid enrollment for an incarcerated individual became available in May 2017. The language was included in the Human Services Code during the 2016-17 budget negotiations.

By connecting individuals to MA benefits immediately upon, or closely following discharge, and utilizing the connection to the Opioid Use Disorder (OUD)-Centers of Excellence (COEs), there are likely to be fewer opportunities for recidivism as a result of the underlying OUD, reductions in co-occurring behavioral health and physical health issues, and continued paths to treatment and ultimately, recovery.

2. **Access to appropriate levels of community-based treatment and supports.**
DHS works to ensure access to appropriate care for all individuals with mental health treatment needs. We also work in partnership with the DOC, PCCD, counties, and other state and local partners to make sure that individuals with SMI have access to treatment and supports during all phases of the criminal justice process. We have a shared responsibility to provide timely access to care upon discharge from jail or prison to both improve the health outcomes for individuals with SMI and to reduce the likelihood of negative outcomes when individuals end treatment.

Behavioral Health HealthChoices is the major source of funding available to meet the treatment needs of individuals with SMI across the commonwealth. The timely enrollment of eligible individuals is essential to assuring continuity of care for individuals coming out of prison or jail.

3. **Access to medications throughout the transition to community living.**
There are three key issues related to medication management for individuals with SMI: 1) consistent and proper use of medications that are effective for the individual; 2) access to a continued supply of the same medication during transition into or out of prison or jail, and 3) consistent use of the medication by the individual with SMI.

It is important to find a treatment and medication regimen that is effective for each individual with SMI. For individuals transitioning through the justice system it is important to avoid abrupt changes in psychotropic medications and to maintain access to medications particularly after discharge from the prison or jail. DOC has adopted protocol to provide up to a 30-day supply to support the medication needs of individuals leaving prison. This helps the individual continue their medication regimen during the transition from receiving care in prison to receiving care from a provider through Behavioral Health HealthChoices or other coverage.

4. **Access to care coordination and oversight from both the clinical and recovery perspective as well as from the probation and parole perspectives to help ensure engagement in treatment following discharge.**
   Individuals with SMI should not be involved in the criminal justice system solely because of their mental illness or lack of access to behavioral health services. They also should not be involved in the criminal justice system longer because they have a mental illness. Those incarcerated need access to timely, effective, and ongoing treatment. Cross-system and cross-discipline collaboration is essential to connecting individuals with SMI to appropriate treatment.

   In 2009, OMHSAS collaborated with PCCD to create the Mental Health and Justice Advisory Committee that includes representatives from state agencies, county leadership, the courts, district attorneys, public defenders, consumers and families, and other justice and mental health advocates and practitioners. The Mental Health and Justice Advisory Committee works to expand successful use of evidence-based practices for justice-involved individuals with mental illness and co-occurring substance use disorders. The Committee also works to improve the capabilities of local communities to reduce the involvement of individuals with mental illness and co-occurring disorders in the criminal justice system. Specialty Courts are one strategy used by counties to better respond to individuals' serious behavioral health issues.

5. **Access to housing arrangements that reasonably support participation in treatment and movement forward in recovery.**
   Housing for individuals living with behavioral health disorders is an important factor in assuring successful community integration. At least 53 counties have made reinvestment resources available as part of the OMHSAS Permanent Supportive Housing Initiative. The goals of this initiative are to create affordable supportive housing for people with disabilities; to utilize Health Choices Reinvestment funds, CHIPPS or base funding to access and leverage mainstream housing resources; and, to create partnerships with state and local housing and community development entities.

Collaborative and Community-Based Diversion and Re-entry Efforts

With adequate treatment and support services, many individuals are successfully diverted from entering, or re-entering, the justice system. For those individuals that are not able to be diverted from the criminal justice system, many can make a successful re-entry to the community with a strong support system and adequate resources.

Focus on the reentry process is a high priority for inter-systems coordination and collaboration. OMHSAS works together with the DOC, the PA Board of Probation and Parole, and county partners to address the re-entry needs of individuals in the criminal justice system.

Individuals returning to the community post-incarceration often struggle with problems of limited housing options, job skills, education, opportunities for work, and access to health care. Individuals with mental health and substance use disorders often face more complex challenges related to access to treatment and benefits and marginalization from natural and community supports.

Individuals with more specific clinical issues – (for example, sex offenders, individuals with dementia, medically-compromised individuals, individuals with traumatic brain injury, and persons with co-occurring substance use disorders) may not have access to the specialized services necessary to meet these needs in the community.

DHS, system partners, and Pennsylvania communities have developed targeted strategies to increase diversion of people with SMI and concurrent complex challenges from the criminal justice system and to link them with community treatment and resources. The Mental Health and Justice Advisory Committee has provided mental health and criminal justice stakeholders with an opportunity to collaborate on a wide range of statewide, regional, and county initiatives and trainings within each of the intercepts.

A number of statewide initiatives at each intercept have been developed, including Mental Health First Aid and Crisis Intervention Team Training of law enforcement; 100 problem solving courts, including 10 Mental Health Treatment Courts; Certified Peer Specialist Training within state correctional institutions; a Statewide Forensic Peer Support Specialist Program; Cross System Mapping/ Action Plan workshops highlighted statewide challenges related to access to housing, transportation, and employment; Enhanced re-entry planning efforts (County Mental Health Forensic Liaisons & Enhanced Reentry Planning Committee); and, supportive permanent housing programs.

Improving Access to Whole-Person Behavioral Health Care before and after Incarceration
DHS has a number of emerging strategies that focus on person-centered care, behavioral health and physical health integration, increased access to and quality of care, and team-based approaches to care management. Key concepts of care coordination include engagement activities at key points of potential service initiation, communication between service providers, and support for treatment and non-treatment needs.

Examples of initiatives that promote integration and coordination of care are Certified Community Behavioral Health Clinics (CCBHCs) and OUD COEs. CCBHCs provide intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, and treatment, prevention and wellness services. Each CCBHC possesses the skills necessary to make the significant changes we're working towards in transforming behavioral health services across Pennsylvania. OUD COEs are a central, efficient hub around which treatment revolves. By keeping individuals with OUD engaged in high quality, coordinated, and whole-person treatment, they have a better chance of moving towards recovery, having reduced medical costs, and reducing criminal justice involvement. OUD-COE care management teams are expected to

work within their local community to accept transfers of individuals with OUD from state and county corrections facilities.

Stepping Up Initiative

Despite significant efforts over the last several years, counties across the Commonwealth of Pennsylvania report a significant over-representation of people with mental illnesses in their jails. To help counties to address this problem, a collaboration of state government partners and county leaders are undertaking *Stepping Up Pennsylvania*, a multi-year initiative focused on assisting Pennsylvania's counties in achieving measurable reductions in the number of people with mental illnesses in Pennsylvania's jails through the application of Stepping Up's data-driven, systems-level action framework. Stepping Up Pennsylvania was formally launched and announced by state-level partners and national initiative partners at the Criminal Justice Advisory Board conference in April 2017.

Stepping Up Pennsylvania coordinates closely with the national Stepping Up Initiative, which was launched in May 2015 and is led by the Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association, and is supported by the U.S. Department of Justice Bureau of Justice Assistance and philanthropy. To date, more than 320 counties in 42 states—including 12 counties within the Commonwealth of Pennsylvania—have joined Stepping Up and are working to apply Stepping Up's action framework to achieve the goal of fewer people with mental illnesses in jails. The goals of Stepping Up Pennsylvania are to:

- Increase the number of Pennsylvania counties that join the initiative and formally commit to Stepping Up's goal of reducing the number of people with mental illnesses in jail.
- Increase the number of Pennsylvania counties that apply a data-driven, systems-level framework for reducing people with mental illnesses in their jails.
- Increase the number of Pennsylvania counties that have accurate real-time data on the number of people with mental illnesses in their jails.
- Help counties enhance appropriate diversion options, reentry assistance, and connections to community-based treatment, services, and housing.
- Ensure that state-level policy and funding supports are aligned with county-driven efforts to reduce the number of people with mental illnesses in jails.

The initiative will achieve these goals through direct county engagement; action planning assistance to help local leaders assess their current level of progress around several dimensions, identify strategic priorities, and identify gaps in existing programming and services; and, data collection and analysis support to help counties develop systems for measuring the performance of programs and policies on the number of people with mental illness in jails. The initiative is focused specifically on four metrics: the rate of jail bookings, the average length of stay in jail, connections to treatment, and the rate of recidivism.

Conclusion

It is DHS' goal to ensure people have access to services and supports when and where needed. People with SMI can and do recover and lead meaningful lives as productive members of our communities. Criminal justice and mental health professionals play an important role in supporting recovery, by remaining optimistic, conveying hope, and focusing on strengths and success.

DHS' aim is to ensure the successful transition of inmates to the community and a reduction in recidivism of individuals with SMI. To accomplish this aim, DHS is directing resources at the state and local level to divert individuals with SMI from the criminal justice system whenever possible; delivering appropriate assessment and treatment for people with SMI who are incarcerated; and providing comprehensive planning and support services for individuals with SMI as they return to the community after time in prison or jail. The overarching goal is to ensure successful return of prisoners to the community and a reduction in recidivism for individuals with SMI.

Thank you for the opportunity to provide this information to you today and to explain the continuity of care available to meet the needs of individuals with mental illness who become involved in the criminal justice system. We would be happy to meet with you to discuss DHS's current strategies and any legislative proposals relating to mental health treatment and the criminal justice system.

PACA MH/DS
Pennsylvania Association of County Administrators of Mental Health and Developmental Services

November 27, 2017

The Honorable Representative Davidson
38 A East Wing
PO Box 202164
Harrisburg, PA 17120-2164

Dear Honorable Representative Davidson:

This testimony is on behalf of the Pennsylvania Association of County Administrators for Mental Health and Developmental Services (PACA MH/DS) to offer comments on your mental health reform package. PACA MH/DS is an affiliate of the County Commissioners Association of Pennsylvania (CCAP). PACA MH/DS represents all the 48 county-based entities responsible for administration of mental health and intellectual disability services across 67 counties, as well as 21 behavioral HealthChoices oversight entities and 53 supports coordination organizations for intellectual disability services.

First, thank you for your willingness to support community mental health services to ensure individuals with mental illness can receive necessary treatment. Your attention and voice are welcome in creating additional awareness regarding the challenges to the mental health service delivery system grapples with daily. We greatly appreciate that you recognize the county role in addressing mental health needs in the community and that you are striving to improve access to these vital services.

As an affiliate of CCAP we have worked collaboratively with the Comprehensive Behavioral Health Task Force and their continued activities to address the needs of individuals with mental illness who are involved with the criminal justice system. The task force has developed a report which outlines strategies that counties may use to address the needs of this population. In addition, PACA MH/S supports efforts to provide expedited enrollment in Medical Assistance for eligible offenders upon release and continues to support voluntary mental health courts to divert individuals from the justice system when appropriate.

The remainder of this testimony will address the individual legislative proposals outlined in your mental health reform package.

HB 1630 – Assertive Community Treatment Team (ACT)

The Substance Abuse and Mental Health Services Administration recognizes ACT as an evidenced based practice that requires specific credentialed staff including psychiatrist, psychiatric nurses, and substance abuse and mental health counselors. As the majority of Pennsylvania is rural in nature, ACT approach is difficult statewide due to the lack of resources and the ability to sustain the cost for the number of individuals involved. Nationally we face a shortage of psychiatrists and Pennsylvania is no exception. In addition, in light of the vast number of rural communities, frequently there are not a sufficient number of individuals locally to sustain a team. ACT currently operates in many of our more urban areas where the staff resources are more readily available.

PACA MH/DS supports ACT where feasible and would support regulations that reflect the practice if promulgated, but do not believe that a mandate is financially feasible for statewide implementation. In fact, more areas are serving individuals with Community Treatment Teams that do not meet with the high fidelity standards of ACT, but do have a multi-disciplinary team providing a wide range of intensive services twenty-four hours a day. With sufficient funding, intensive community services can be created to assist in sustaining people with severe mental illness.

House Bill 1629 – Requiring Health Insurance Coverage for ACT

PACA MH/DS supports parity for mental health services. Unfortunately, insurance companies do not have services for individuals with persistent and severe mental illness. With the continued challenges to the Affordable Care Act and the potential to lose mental health services as an essential benefit, we support increased access through improved mental health coverage. Yet, the private sector will face the same human resource constraints as counties face. PACA MH/DS would welcome discussion on what would be of benefit to include in private insurance coverage and counties are the place people turn to when there is no coverage under their insurance or they are not otherwise eligible for services but are experiencing difficulties due to mental illness.

House Bill 2512 – Amend MHPA for Next of Kin Notification of Admissions to MH Facility

PACA MH/DS fully understands the intent of this bill. Unfortunately, even if state law is changed, the various federal standard are in force. The Health Insurance Portability and Accountability Act of 1996 is the cornerstone of federal law. State laws are enacted to assist in creating a level of trust between a physician and patient, which is critical in addressing mental illness. Individuals with mental illness have a choice to create Mental Health Advance Directive according to Act 194 of 2004. This law promotes planning ahead for the mental health services and supports during a period of crisis, including notification of specific individuals. Individuals can also create a Wellness Recovery Action Plan (WRAP) is a self-designed plan to assist individuals in recovery.

PACA MH/DS understands the frustration of confidentiality laws in Pennsylvania. Confidentiality for individuals experiencing substance abuse is the most restrictive of the human service confidentiality standards. Counties work diligently to support providers in securing sufficient release of information to provide coordinated and appropriate treatment.

House Bill 2514 – Alerts for Missing Endangered Person Advisory System

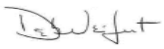
PACA MH/DS does not have a formal position on the use of alerts for individuals with disability. Our members are cautious in regards to notification of the public regarding individuals in treatment. We support and implement Tarasoff decision (Tarasoff v. Regents of the University of California 1976) that requires mental health professionals to notify individuals who are being threatened with bodily harm stated during the course of treatment. Yet, counties and providers are cautious in order to prevent inadvertently violating an individual's confidentiality.

PACA MH/DS would suggest that the bill indicate who has the authority to determine and report the missing and endangered person if it differs from the current Pennsylvania Missing Endangered person Advisory System.

PACA MH/DS continues to examine current law and regulations to promote practices that address the needs our members see every day in the community. Our most recent White Paper regarding the Mental Health Procedures Act is an excellent example of our awareness to the changing needs of society. We understand that alternative approaches are needed to create opportunities for voluntary treatment to address the underlying concerns that result in crisis or illegal acts. A copy is included with this testimony.

Please continue to champion community mental health services. The continued erosion of funding over decades is now creating increased pressure during a time of ever increasing concerns; community services need sufficient resources to assist individuals partaking in at-risk behaviors as well as when a crisis arises. Please feel free to contact our association for further discussion on your legislation or other potential proposals.

Sincerely,



Deb Neifert
Deputy Director