



NAMI Southwestern Pennsylvania Talking Points against HB 2186 and SB 251

NAMI Southwestern PA is Opposed to the Current Legislative Efforts to Expand Outpatient Commitment under the Mental Health Procedures Act

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Current legislative efforts in the PA General Assembly via **HB 2186** and **SB 251** proposing the inclusion of “Assisted” Outpatient Treatment (AOT) into the Mental Health Procedures Act, while no doubt good intentioned, do little to ensure that all individuals have continuous and timely access to a full and fully funded continuum of community based recovery oriented behavioral health treatment. It is worth noting that Outpatient Commitment is already in place within the Mental Health Procedures Act (MHPA) of 1976 (50 P.S. 7101) governing both voluntary and involuntary commitments.

- Both the House and Senate versions of the current AOT legislation create new mandates, but offer no new funding, for individuals under an AOT to be assigned a case manager or assertive community treatment team. The introduction of New York’s AOT Program, commonly known as Kendra’s Law, was accompanied by a significant infusion of new service dollars. An annual total of \$32 million was appropriated for direct support of AOT Programs. This appropriation included \$9.55 million per year to fund anticipated case management expansion for AOT recipients.
- Additionally the legislation calls for compliance (but again no mandate for funding) with any and all of an array of outpatient services *as long as they are called out within the AOT court order* including; medication compliance, blood tests and other laboratory procedure compliance to supervision of living arrangements.
- These unfunded mandated services would unduly burden an already financially strained community provider system during a time of economic uncertainty. And in doing so would shift costs from recovery focused treatment and supports that work, to those that are coercive through AOT.
- Those individuals mandated to comply as a condition of the AOT would “fast-track” to services conceivably forcing those who are seeking services voluntarily to the back of the line or onto a “waiting list”.
- Forced treatment has been shown to prompt distrust and at times anger, often failing to engage the very people needing the treatment. Forced treatment bodes less well for gained insight and partnership in treatment decisions between individuals, their significant others and their treatment providers. Treatment success is better realized when an individual with serious and persistent mental illness has real choice about the services that will best meet his or her needs.
- Although AOT legislation calls out for mandated services (forced treatment) an individual may still refuse to comply with the mandates thus compelling a family member or case manager or others to contact the police. Clearly this does not prompt engagement or person-centered treatment.

NAMI Southwestern Pennsylvania would call for opposition to the legislative efforts proposed through HB 2186 and SB 251 and cite a preferred means to ensure that all individuals have continuous and timely access to a full and fully funded continuum of recovery oriented treatment and supports by ensuring for:

- **MH Procedures Act Training Initiative** Development of an education curriculum and funded training initiative to allow for County MH Delegates/Review Officers to have greater understanding and compliance with existing commitment criteria with consistency.
- **Issuance of PA DPW Bulletin on Mental Health Procedures Act** that better defines the standards for involuntary commitment noting that threat of harm with “an act in furtherance of” that threat is but only one of the standards that may be considered thus acknowledging other criteria may be used.
- **Expanded use state-wide of individualized acute community support planning (CSP) in lieu of AOT** in discharge planning from community psychiatric inpatient units. A June 2009 Duke University School of Medicine study of New York State AOT cites 84% of people court ordered to AOT had been so deemed at time of discharge from a community hospital.
- **Mental Health Advance Directives.** State wide expansion of a funded education initiative prompting more individuals to utilize this legal document proven to increase communication and partnership between individuals, their significant others and treatment providers while decreasing anxiety and fear associated with inpatient treatment.
- **Ongoing responsible downsizing /closure of state operated mental health hospitals.** Thoughtful planning to continue the closure of state hospitals will allow for the shift in moving funds from the state hospital line item to that of community mental health services. Adequate funding for community treatment and supports will increase service capacity and promote recovery within community settings.
- **Continued shift from utilizing limited MH funding in “Bricks and Mortar”** by increasing cooperative partnerships with like-minded or outside entities to expand permanent supportive housing options. This allows for counties and community providers to provide more “services” while other qualified entities are responsible for funding or partially funding the “supports” (IE: housing).
- **State wide expansion of mental health court initiatives** designed to promote treatment in the community in lieu of incarceration.

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