

Testimony on the Mental Health Involuntary Commitment Process

Dr. Dale Adair, Medical Director and Chief Psychiatric Officer

Office of Mental Health and Substance Abuse Services

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Good morning Chairwomen Vance and Kitchen, members of the Senate Public Health and Welfare Committee, and staff. My name is Dr. Dale Adair, and I am the Medical Director and Chief Psychiatric Officer of the Office of Mental Health and Substance Abuse Services (OMHSAS) within the Department of Human Services (DHS). I am joined here today by my colleague Jean Rush, the Division Director of the Bureau of Policy, Planning and Program Development at OMHSAS. On behalf of Secretary Dallas, we would like to thank you for the opportunity to present testimony regarding continuity of care for individuals with mental illness who have been involuntarily committed to psychiatric inpatient treatment.

Many refer to our mental health system as being broken. I prefer to speak of it as facing multiple challenges. When speaking of mental health issues, words matter, and I believe the term “challenges” denotes a more positive and hopeful outcome. Mental wellness is about conveying a sense of hope, because we know that treatment does work. Part of my job, our job, is to give those faced with mental health concerns a reason to hope.

In Pennsylvania, there are two ways to enter mental health treatment: voluntary admission and involuntary commitment. The 201, or voluntary admission, is how the majority of individuals receive services; an individual decides he or she needs assistance and actively seeks help. When an individual is either unaware of the need for treatment, or unwilling to accept assistance, or both, then the 302 process for involuntary commitment is utilized. This can be a traumatic experience for the individual, family, friend, or treatment provider who has to petition for the commitment. The Mental Health Procedures Act (Act) specifies the commitment process, which requires that the individual must be dangerous to self or others and have a mental illness.

Our commitment laws do not focus on individuals with co-occurring disorders, such as mental health and substance use. It is generally believed that the majority of individuals requiring re-hospitalization have both mental health and substance use disorders. Data from a recent DHS study revealed that for individuals with chronic medical conditions, along with mental health and substance use, there was a statistically significant readmission rate. This underscores the importance of coordination of care and treating the whole person. Part of our challenge has been slightly different interpretations of the Act by the various counties.

Once an individual has received inpatient care, the transition to outpatient care can be challenging. Studies have shown that by reducing the time interval between discharge and follow-up we can improve outcomes such as post-hospitalization suicide rates. DHS, in fulfilling the federally mandated performance improvement activity required in the HealthChoices Program, has initiated a three-year Study and Performance Improvement Project (PIP) called Successful Transitions to Ambulatory Care. The goal of this performance improvement activity is to decrease the behavioral health (both mental health and substance use) readmission within 30 days after discharge from an inpatient level of care. One of the performance indicators for this PIP is the National Healthcare Effectiveness Data and Information Set (HEDIS*) 7-day Follow-up after hospitalization from Mental Illness measure. The goal is that an individual is seen through a follow-up appointment within seven days of being discharged to improve outcomes. In some cases, it may be imperative that the individual is seen as soon as he or she is discharged. DHS currently has an ongoing study assessing the frequency of follow-up.

DHS is promoting efforts aimed at improving timely access to quality care and treatment such as telepsychiatry, Patient-Centered Medical Homes, participation in the Innovation Accelerator Program for Substance Use Disorder High Intensity Learning Collaborative (IAP-

SUD HILC), the study of First Episode Psychosis (FEP), and a grant to explore the development of Certified Community Behavioral Health Clinics (CCBHCs) in Pennsylvania. I will discuss telepsychiatry, FEP and CCBHC in more detail after providing an overview of the recent efforts by OMHSAS to provide consistent information on the interpretation of the Mental Health Procedures Act.

The Act established not only the standards for voluntary and involuntary treatment, but also the state policy recognizing that treatment on a voluntary basis is preferred to involuntary treatment. The policy also recognizes that adequate treatment should be provided with the least restrictions possible in all commitment cases.

As research has identified a variety of evidence-based practices to treat individuals with serious mental illness in the community and recognizes that individuals with serious mental illness can and do recover with adequate treatment and supports, the mental health system has continued to enhance community-based resources.

Two of the key services available in every county are crisis intervention and emergency services to provide an immediate response to individuals and families in crisis. These services seek to ameliorate or resolve the precipitating stressors, which threaten the well-being of the individual or others in the least restrictive manner appropriate to the needs of the individual. Counties have developed a variety of structures to provide crisis intervention and emergency services, which has impacted consistent implementation of the Act. The ability to provide an appropriate crisis intervention or emergency services response contributes to an individual's recovery, decreases the need for more restrictive interventions, and supports the Act's statement of policy ensuring adequate treatment with the least restrictions to meet the individual's needs.

Over the past year, OMHSAS has met with a variety of stakeholders regarding the need for resources to assist counties and providers in the consistent interpretation of the Act. For example, stakeholders indicated the interpretation of the legal standard of clear and present danger can vary across the state. Each emergency situation is different and the interpretation will vary based upon the unique presentation of clear and present danger but consistent understanding of the Act and case law will provide standardization across counties and providers. As a result, a stakeholder workgroup representing counties, providers, consumers, family members and advocacy organizations was convened to provide input into the development of a framework for standardized crisis intervention and emergency services training material. The goal is to provide information that will assist in the consistent interpretation and implementation of the Act in each county. As an example, the delegates in all counties would have the same training and information on the Act in order to be able to apply the legal standard of clear and present danger consistently in determining whether the statutory standard for issuing a warrant for an involuntary examination have been met, rather than each county relying on its own interpretation of the Act.

To address the challenge of providing standardized training on a service that is required to be available 24/7, a variety of training resources are under development. To begin the process, four regional trainings were held in the spring of 2015. Sixty-three counties participated in the training with 250 professionals in attendance. The primary focus of the training was an overview of the Act, which was provided by the DHS Office of General Counsel (OGC), and included information on current case law interpreting the Act, as well as the opportunity for attendees to ask questions. The evaluation indicated an 87 percent satisfaction rate with the content of the training and numerous requests for additional training information and resources.

Next, an online training manual is under development in collaboration with Temple University and the stakeholder workgroup members who provided input into the development and material that should be included as part of the training resources. The manual is designed to provide an overview of the laws and regulations governing voluntary and involuntary treatment standards, and will include information on the interpretation of the Act, training scenarios to enhance skill development and consistency, overview of crisis intervention theory, skill building modules for key crisis/emergency intervention, engagement and intervention skills for special populations and effective ways to collaborate with community partners, such as police and emergency department physicians who are integral in the delivery of emergency mental health services. Each section will include a post test, skill building activities, and links to research information to enhance the current knowledge base. The goal is to provide the information to all counties electronically by the end of this calendar year.

Finally, a series of training CDs will be developed as an additional resource to the training manual and to provide additional information on key areas of the Act to DHS's community partners.

Access to care is directly impacted by the number of available providers. For at least the last decade, if not longer, there has been a shortage of available psychiatrists and other behavioral health providers, especially in rural areas. One way we have utilized available technologies to address these needs is through the use of telepsychiatry, which allows an individual to access psychiatric services by phone instead of visiting a doctor's office. Telepsychiatry is a service that has grown in practice since its inception. DHS has approved 61 unique providers that provide services over 164 different sites throughout the Commonwealth.

Between 2010 and 2014, we have seen an increase of 1274% in billable encounters. There is still room to grow and improve.

First Episode Psychosis is a practice that prioritizes early intervention and treatment. The age at which psychosis usually develops is late adolescence or early adulthood, generally between the ages of 16 and 24. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) administers the Mental Health Block Grant and has added funding for states to develop programs aimed at addressing those with new onset psychosis. Last year, OMHSAS provided funding to two programs, University of Pennsylvania's Psychosis Evaluation and Recovery Center and University of Pittsburgh's Western Psychiatric Institute and Clinic. This year we have agreed to fund two additional programs, Psychosis, Education, Assessment, Care and Empowerment (PEACE) program in Philadelphia and Safe Harbor in Erie. Studies have shown that early intervention helps improve overall health outcomes and quality of life. The programs focus on school retention, supported employment and engagement in treatment which are key areas to address for individuals experiencing first episode psychosis. Growing evidence also supports early identification of persons most likely to develop psychosis, before they demonstrate psychosis, at which point intervention may prevent the symptoms from emerging into a first episode.

OMHSAS has collaborated with the Department of Drug and Alcohol Programs (DDAP) to submit an application for a one-year Certified Community Behavioral Health Clinics (CCBHC) planning grant. The goal of CCBHC is to improve access and quality of care for some of the Commonwealth's most vulnerable individuals. The grant is sponsored by SAMHSA, and funds will be awarded to up to twenty-five states to plan a process to certify clinics, which will provide treatment to: 1) individuals with serious mental illness; 2) children with serious

emotional disturbance; and 3) individuals with substance use disorder. The care would be person and family-centered and integrate physical health services. DHS would also have to develop a prospective payment system to pay for the services provided, and plans to build in a bonus payment structure for meeting quality measure indicators such as follow up after hospitalization for mental illness. DHS believes approximately 300 entities throughout the Commonwealth would be eligible to become CCBHCs. The clinics would be certified by DHS to complete needs assessments and deliver evidence-based treatment which would meet the needs of the population served. This will fundamentally change the way outpatient care is currently provided and is considered a game changer.

In the current behavioral health system, inpatient psychiatric treatment, partial hospitalization programs, psychiatric outpatient clinic services, mobile mental health treatment, crisis intervention services, laboratory and diagnostic services, medications, targeted case management, peer support services, behavioral health rehabilitation services for children and adolescents, family based treatment, outpatient drug and alcohol treatment, and methadone maintenance services are covered community-based services funded by Medicaid to ensure continuity of care for individuals in need of treatment in Pennsylvania. Additionally, in the HealthChoices program, counties can develop an array of supplemental behavioral health services upon approval by DHS to enhance the current service system. Assertive Community Treatment, psychiatric rehabilitation services, and supportive housing resources are some examples of services available in some counties. While significant challenges remain within Pennsylvania's behavioral health system, we are making significant progress in moving Pennsylvania forward and providing hope to those who need it the most.

Thank you for the opportunity to provide this information to you today. We would be happy to take any questions you may have at this time.