

**Testimony of
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**to the
Senate Public Health and Welfare Committee
Public Hearings for Senate Bill 226
Hearing Room One, North Office Building
State Capitol
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My name is Joseph Rogers, and I am the President for Policy and Advocacy of the Mental Health Association of Southeastern Pennsylvania. Thank you for the opportunity to speak to you today.

I urge you to reject S.B. 226, which would amend the Mental Health Procedures Act to provide for involuntary outpatient commitment, also called “assisted outpatient treatment.”

I believe that the bill has grown out of a sincere desire to help people with mental illnesses. Unfortunately, if it became law, it would have exactly the opposite effect. It would allow the state to force treatment (usually involving medication) on people living in the community, under threat of involuntary hospitalization if they don't comply. This is a very bad idea.

I have been involuntarily committed and force-medicated, and I can tell you from personal experience that coercive treatment methods simply do not work — and they represent a poor substitute for building comprehensive, community-based mental health and social support services. In fact, force and coercion have been proven to drive people away from treatment, and such methods are ineffective and expensive. Particularly horrible is the use of physical force, coercion, or intimidation in the administration of psychotropic medications. Yet mandatory outpatient treatment statutes seem to invite such violations.

There is an alternative to force and coercion. By fostering trusting and stable relationships while emphasizing choice in clinical decisions, it is possible to achieve extraordinarily high rates of adherence to treatment plans. For example, the success of the Mental Health Association of Southeastern Pennsylvania's peer-to-peer services is dependent upon a combination of innovative thinking and the exercise of free will – not coercion.

It is vital to note that outpatient commitment statutes are not widely viewed as helpful in the public mental health system. Although many states have such a statute, most states use it only rarely, according to a survey of state mental health commissioners by the National Association of State Mental Health Program Directors. There is a good reason for this. Many states, in fact, choose not to implement their outpatient commitment statutes because they possess a woefully inadequate system of community-based services.

In addition, the cost of enforcing involuntary outpatient commitment diverts resources away from those mental health consumers already receiving care. The harsh reality is that improving care for people who have mental illnesses costs money; and no legislative mandate will get the job done without expanded resources. If you do enact S.B. 226, then you will also need to increase the mental health services appropriation by a huge percentage.

An alternative to involuntary outpatient commitment is a statute already on the books in Pennsylvania, giving psychiatric advance directives the weight of law; and we applaud the General Assembly for having passed this legislation in 2005. Psychiatric advance directives are written documents in which an individual expresses his treatment preferences so that, if he later is not in his sound mind, his preferences can be adhered to. The individual can also identify someone to act as a health care agent who can make sure his wishes are respected. The use of such documents should be promoted through establishing avenues to help people create them, rather than just providing people with information about them. A study published in 2006 in the American Journal of Psychiatry found that 61 percent of participants in a facilitated advance directive session completed such a document or authorized a proxy decision maker, compared with only 3 percent of people in a control group, who only received written information about advance directives.

The most compelling argument against S.B. 226 is that outpatient commitment is not effective. A controlled trial study at Bellevue Hospital in New York City found that what helped clients was intensive services; whether they received the services voluntarily or under court order was not significant.

According to the Bazelon Center for Mental Health Law, other studies that have been cited as evidence that outpatient commitment leads to better outcomes have serious methodological flaws, and their results have been misunderstood and misrepresented. A Rand research team's review of the experience of eight states with involuntary outpatient commitment statutes – Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington and Wisconsin – found “significant problems” in all eight. The Rand researchers found that the mental health systems in states with such laws were inadequate to the task of implementing court-mandated treatment. As a result, the laws often fell into disuse. In addition, the Rand report stated, “There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes.”

The Rand researchers also conducted a literature review of research on the effectiveness of new models of public mental health care that provided clients with autonomy and choice. “In contrast,” the researchers noted, “the literature provides clear evidence that alternative community-based health treatment programs can produce good outcomes for people with severe mental illness.”

Another serious problem with S.B. 226 is that the criteria that are used to determine when someone can be committed on an outpatient basis are often much less stringent, and far less objective, than the inpatient commitment criteria (which involve deciding whether someone is a danger to self or others). This means that individuals are at risk of losing their fundamental human rights often due only to the fact that they have a mental illness and have not been offered effective treatment. Their supposed “lack of insight” may boil down simply to disagreement with the treating professional. In fact, the only standard for commitment that has been found constitutional by the Supreme Court is “imminent, significant physical harm to self or others.”

The mental health consumer advocacy community and citizen advocacy organizations are united in their opposition to outpatient commitment, which only results in more coercion and in the draining of vital resources that could be much better spent on enhanced community-based services and supports, such as employment, housing and case management programs.

Pennsylvania has a stated commitment to moving toward a recovery-oriented mental health system. S.B. 226 is completely inconsistent with this commitment.

Thank you for allowing me to speak here today and I am happy to answer any questions you may have.

Submitted by:

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