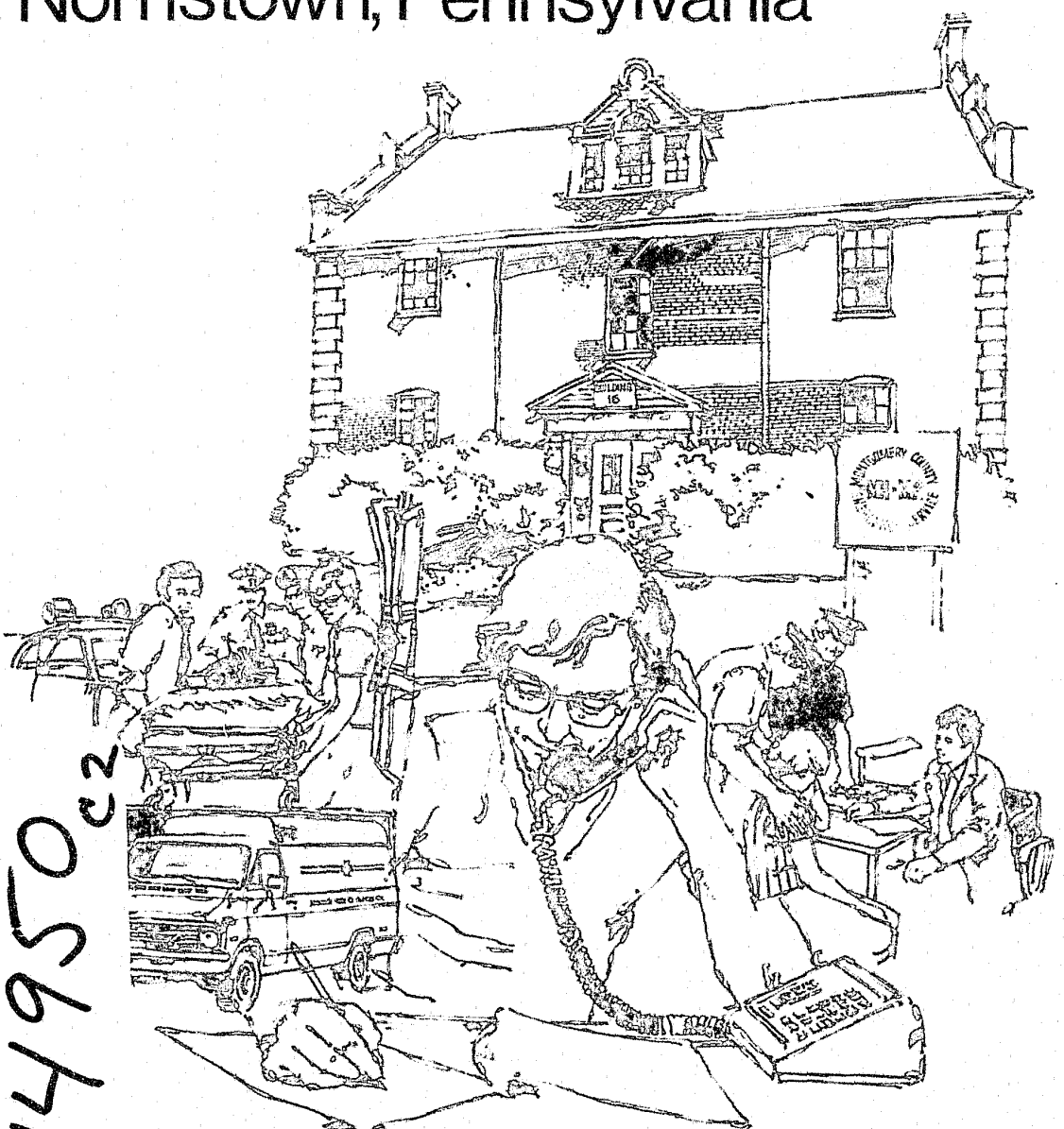
Montgomery County Emergency Service

Norristown, Pennsylvania



Office of Development, Testing and Dissemination
National Institute of Law Enforcement and Criminal Justice
Law Enforcement Assistance Administration
U.S. Department of Justice

An Exemplary Project

NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE

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March 1978

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Abstract

Police are on duty around the clock. As the only available service agency during many hours of the day, they must cope with a variety of social problems, among them psychiatric and drug and alcohol emergencies that may not be criminal offenses but nevertheless pose a threat to the individual and the community. Few jurisdictions have developed a centralized system to provide care for people in such circumstances. One that has is Montgomery County, Pennsylvania.

The Montgomery County Emergency Service (MCES) is a private, nonprofit corporation and a fully-licensed and accredited psychiatric hospital which offers psychiatric and drug and alcohol emergency service. MCES services include telephone "hot-line" assistance, a specially equipped emergency ambulance, psychiatric evaluation, detoxification, short-term hospitalization, and referral to other agencies for continuing care.

To assist police in handling these emergencies, MCES formed a Criminal Justice Liaison Network by placing trained human service workers in selected police departments.

Since MCES opened its doors in February 1974, 30 percent of its client contacts have been criminal justice referrals.

By designating MCES an Exemplary Project, the National Institute recognizes it as a viable alternative to arrest in various crisis situations. This manual is being published to provide information to other communities interested in developing a similar program.

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Chapter 1 Introduction

1.1 The Problem

CRISIS --

A woman, dazed and confused, wanders through the traffic on busy Main Street. She reeks of alcohol....

CRISIS--

An emotionally disturbed teenager threatens destruction of his neighbor's property. His parents' attempts to restrain him fail....

CRISIS--

A child has been assaulted. The distraught father, vowing revenge, searches for a weapon....

Call the police!--the instant and most obvious response to an emergency. But are the police best equipped to cope with such crises?

--Is the "drunk tank" the answer for the alcoholic?

--Are screaming sirens and handcuffs the solution for the disturbed youth?

--Will a night in jail "cool off" the potentially violent father?

Probably not. But arrest and emergency detention are often the only available course of action for overburdened police who are

called on to deal with urgent mental health, mental retardation, drug or alcohol problems.

The consequences of traditional crisis processing?

For the individual--inadequate and possibly detrimental treatment at the most critical moments.

For the police--diversion of valuable manpower.

1.2 A Solution

In Montgomery County, Pennsylvania, the Mental Health Administrator's Office studied the problem and found that the police had only two alternatives to arrest and detention: community mental health centers and local hospitals. Neither were well-equipped to handle most drug, alcohol or mental health/mental retardation emergencies. Mental health centers did not operate on a 24-hour basis, and many hospitals were reluctant to accept these kinds of patients.

Clearly, an alternative was needed:

- to provide the county with 24-hour psychiatric and drug and alcohol emergency service; and
- to alleviate the burden on police by assuming responsibility for these potentially dangerous situations.

With the support of the judiciary, police, and social service agencies, the Montgomery County Mental Health/Mental Retardation Emergency Service, Inc. (MCES) opened its doors in January 1974 to provide this alternative.

MCES is a private, nonprofit corporation and a fully-licensed and accredited psychiatric hospital with 24 beds and a staff of 90 full- and part-time administrative, medical, and support personnel. MCES is devoted primarily to the immediate, short-term needs of psychiatric and drug and alcohol emergencies.

Police escort an inebriated woman to MCES for detoxification.

1.3 The Services

The Montgomery County Emergency Service provides:

- An Emergency Telephone "Hotline" Service, staffed around-the-clock by experienced intake counselors who provide brief evaluation, counseling, intake into MCES, and referrals to other agencies when necessary. Although the emergency telephone service is aimed primarily at police and the social service community, it is also available to the general public.

  In its first three years of operation, MCES handled more than 6,700 telephone and walk-in contacts.

- Emergency Transportation Service, via an ambulance specially equipped with life-saving devices and staffed by mental health counselors. The ambulance personnel are trained to evaluate and handle violent or disturbed persons, and to assist police or family members in determining the best course of action in an emergency situation. (The ambulance is also used to transport patients to and from referral agencies or the county courthouse.)

  The MCES ambulance has logged over 30,000 miles since August 1974.

- Emergency Pre-Admission Psychiatric Evaluation. A psychiatrist is always on duty to provide evaluation and counseling, and to make admission or referral decisions. In addition, MCES is the only facility in Montgomery County where evaluations for emergency involuntary civil commitment can be performed.

  More than 4,500 clients have been evaluated by the psychiatric staff.

- Referral Services. Almost every contact with MCES results in referral. All referrals are individually arranged with the social service agencies and transportation is often provided by MCES. MCES staff members maintain close contact with the referral agencies to monitor the patient's progress and to offer assistance if needed.

  A survey of patients discharged from MCES and referred

elsewhere during a six-month period in 1976 revealed that 82 percent were either in treatment or had successfully completed treatment at the referral agency. Of 36 referral agencies randomly selected to rate the appropriateness of MCES referrals, only one agency considered the referral unsuitable.

- Short-Term In-Patient Care for those clients requiring hospitalization. The 24-bed unit, which includes eight security rooms, is staffed around-the-clock with professional personnel. Because MCES is primarily an emergency facility, the aim of the in-patient program is remission or stabilization of the patient's condition and rapid referral to an appropriate longer-term program. Treatment services include individual psychotherapy and counseling, recreational and occupational therapy, group therapy, and medication if needed. A team of psychiatrists, psychologists, social workers, registered nurses and mental health counselors provides in-depth evaluation when required through psychological testing, individual counseling, family interviews, and social/medical histories.

  Nearly 3,000 clients have been admitted to the in-patient unit. Average length of stay is 5.8 days.

- Emergency Detoxification for drug or alcohol addicted patients, who can develop serious mental and physical complications during the withdrawal process. Evaluation, referral, and recommendations for further treatment are made after detoxification.

  Typically, one of every three in-patient admissions requires detoxification.

- The Crisis Intervention Outreach Team which provides immediate, on-the-spot support in crisis situations. A team composed of specially trained counselors, on call seven days a week via the emergency telephone service, provides evaluation, counseling, and referral at the time and place of the crisis. A two-way radio provides a direct link to a psychiatrist at MCES.

  Between July 1975 and April 1977 the Crisis Intervention Outreach Team handled 247 cases, resulting in 523 home visits, 87 office visits, and 873 telephone consultations. Though it is not possible to determine how many

actual emergencies were averted through the team's efforts, it is interesting to note that only 15 percent of their cases required in-patient care.

- The Criminal Justice Liaison Program, intended to develop close links between MCES and the county's criminal justice agencies. To achieve this, MCES provides:
  - crisis intervention training for police officers and recruits;
  - consultation and follow-up on all cases in which there has been collaboration;
  - information to criminal justice personnel regarding the availability and uses of the Emergency Service programs; and
  - the Criminal Justice Liaison Network, a program in which human service worker trainees are placed in various county police stations to provide immediate assistance to police officers in handling psychiatric and drug and alcohol emergency cases.

  Between February 1974 and April 1977 over 30 percent of total MCES contacts were criminal justice referrals. More significantly, 41 percent of all MCES admissions were initially referred by the police, suggesting that the police are using MCES services appropriately.

  A three-month study of 152 criminal justice referrals revealed that charges were actually brought in only 34 cases; in most of those cases, charges had been issued prior to MCES referral.

  For evaluation pick-up calls, a burden that had rested solely with the police prior to MCES service, the MCES emergency ambulance logged 970 hours, or over 121 person workdays.

  Though the Liaison Network was only established in the summer of 1976, the six participating police stations are overwhelmingly positive about the program and many other departments have asked to participate.

1.4 The Benefits

MCES has been studied by government, university, and private researchers as well as by its own evaluation staff. The findings are consistent:

- MCES provides a broad range of emergency services;
- its referrals are appropriate and successful; and
- it provides much-needed assistance to local police departments in handling non-criminal emergencies.

The Cost

The yearly budgets for MCES are as follows:

1/74 - 12/74	$630,000
1/75 - 12/75	852,892
1/76 - 12/76	920,433
1/77 - 12/77	1,256,505

The project was originally supported by the county program funds and supplemented with state and federal funds, but after receiving full hospital accreditation, MCES instituted third party billing procedures. Currently, 99 percent of all billings and 80 percent of the entire MCES budget is supported through third party sources such as Medicare, Medical Assistance, and private health insurance payers. After only three years of operation, the total yearly cost to Montgomery County for all MCES facilities on a fee for service basis and after third party payments is approximately $250,000.* Moreover, there is a considerable savings in police manpower and dollars through the use of the emergency ambulance for transportation services.

A Welcome Alternative . . .

As our society has evolved, many of the traditional sources of help and support in times of personal crisis have begun to fade

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* It should be noted, however, that MCES pays only token rent since the facility is located on the grounds of the Norristown State Hospital.

from the scene. The family, the church, and ethnic and neighborhood organizations, once powerful, now exert little of the influence they possessed in days past. The police are often called upon to fill the void left by this change, and many do, in fact, admirably provide assistance to citizens in personal crisis situations. But many citizens are hesitant to request police assistance, and many others are humiliated to receive it.

For help in times of personal or emotional crises, MCES provides a new alternative for the citizens of Montgomery County.

1.5 Guide to the Manual

To provide assistance to other communities interested in developing or coordinating an extensive array of emergency services, this manual presents a detailed description of the concept, operations, and policies of the Montgomery County Emergency Service. Succeeding chapters deal with the following subjects:

Development and Organization. MCES' historical development from legislative mandate to implementation is explored The organization and administration of the Montgomery County Emergency Service also are discussed.

Civil Commitment. This chapter outlines the statutory procedures governing voluntary and involuntary commitment in Pennsylvania. The specific processes utilized by MCES to ensure that individual rights are protected and that statutory requirements are met are detailed.

Services. Who are MCES clients and how do they receive MCES services? These questions are answered in Chapter 4. Each emergency service component is described in depth and several case histories are presented to illustrate client needs and MCES treatment services.

Criminal Justice Liaison. The referral arrangements that MCES has established with police departments are a significant aspect of operating procedures. Police are relieved to a large degree of the burden of handling and transporting individuals experiencing drug, alcohol or psychiatric crises. Furthermore, crisis intervention training is provided to police departments to enable them to cope with any emergency situations that they may encounter.

Referral guidelines and the services available to police departments are examined in this chapter.

Costs. The operating budget of an in-patient emergency facility is substantial. The conversion from grant support to third party reimbursement is discussed here. The steps necessary to accomplish this are described and the benefits of such a conversion are outlined.

Replication Issues. The advantages of providing extensive emergency treatment services under one roof are examined. Each service component is discussed in terms of its replicability.

Results and Evaluation. The success of MCES in meeting its goal is reviewed here. Issues to consider in designing and conducting an evaluation are outlined.

Chapter 2: Development and Organization

> "The need was clearly here and the legislation mandated us to do it, but I can think of innumerable reasons why the concept seemed doomed to failure. We succeeded because key county and agency officials were determined to work together and see this thing through. I guess we recognized that the county had to have it, and we were responsible for seeing that it happened."
>
> --An Incorporator and Board Member of the Montgomery County Mental Health/Mental Retardation Emergency Service, Inc.

The need for an emergency service in Montgomery County was first discussed in the late sixties--seven years later, the Montgomery County Emergency Service received its first patient. The success of MCES is due to the painstaking efforts that were invested in development and are reflected in the continuing proficient delivery of services. This chapter details the history of MCES from legislative mandate to implementation and examines its organization and administration.

2.1 Development

In October of 1966 the Pennsylvania Legislature passed the Mental Health/Mental Retardation Act (PL 96). Modeled on the Federal Act of 1963 establishing community mental health centers, the Pennsylvania Act, among other provisions, mandated mental health centers to provide twenty-four hour emergency psychiatric services and in-patient units.

By 1969, six community mental health centers (referred to as Base Service Units or BSUs in Pennsylvania) had been established in Montgomery County to serve its population of 600,000. Located northwest of Philadelphia, Montgomery County is predominantly a suburban community that has some light industry. The population is generally white and middle income to upper-middle income.

The BSUs were strategically situated throughout the county, which encompasses a large geographical area and has little public transportation. BSUs were operated on a 9-5 basis, five days a week. Although two of the BSUs were affiliated with hospitals, emergency capabilities beyond normal working hours and access to hospital bed space could be provided haphazardly at best. In fact, only a few of the general hospitals in Montgomery County had bed space for psychiatric patients. While beds were available, there were no secured rooms for violent patients. Additionally, payment for services was difficult to arrange in the case of needy patients. Norristown State Hospital was available as a final alternative. However, there were significant administrative difficulties in placing an individual temporarily in the state hospital.

As the BSU medical and administrative directors successfully began to implement the out-patient facilities, their next concerns became providing emergency services at all hours and in-patient bed space. By 1970, few concrete plans had been developed and the County Mental Health/Mental Retardation Administrator decided to accelerate the process. As Administrator, he was responsible for ensuring that the county complied with mental health and mental retardation legislation and regulations. Thus, he invited the medical and administrative directors of each BSU to serve on a board that would consider methods to develop emergency capabilities as expeditiously as possible. At this time, the County Mental Health Administrator was advocating the immediate establishment of a central emergency service. It would be solely a temporary arrangement to fulfill the county's mandate until the local mental health centers were able to implement their own facilities. Papers of incorporation were filed for a Montgomery County Mental Health/Mental Retardation Emergency Service and several meetings were held by the board to decide where and how emergency and in-patient care should be provided.

However, as one administrative director of a BSU acknowledges:

> *"As a board we were really making little headway. While we recognized that there was an immediate necessity for emergency psychiatric coverage, some of us were reluctant to agree to a central service--even if it would only serve as a temporary solution. Basically, the energy we would have to invest in establishing this would hinder our efforts in eventually implementing such services at the BSU level."*

After a year of little progress and lack of agreement among board members regarding the emergency services' design and location, it was decided to expand the membership of the board. Essentially, board members recognized that the development of a solution was hampered by their own preferences--both jurisdictional and personal--and that such an issue should involve a larger segment of the community.

Hence, representatives from the criminal justice system and drug and alcohol agencies were invited to join the board. Efforts were made to obtain an equal and representative distribution from the three fields and to include both professionals and laymen. With the addition of these members, it became apparent that there was not only a substantial interest in developing emergency psychiatric care but a concern that emergency detoxification did not exist for alcoholics and drug addicts.

Board representatives from the criminal justice system were particularly concerned about cases that typically were brought to police attention but clearly needed psychiatric care or detoxification. Montgomery County has 59 separate police departments, many of which have less than ten officers and cannot provide around-the-clock coverage. At times, the police were forced to drive great distances to procure aid for a medical/psychiatric problem or to detain the individual in a cell without proper treatment. Several local newspaper had commented unfavorably on the lack of services afforded such individuals in "drunk tanks" and in jails. Hence, police departments were eager to be relieved of the responsibility and pressure of handling these difficult cases.

Concurrently, Montgomery County Commissioners in 1970 had formed a Drug Commission to examine the extent of drug abuse and available treatment services existing in the area. Police were reporting substantial increases in drug-related arrests. Community service agencies were requesting additional funds and staff to cope with what appeared to be a dramatically growing problem. Emergency services for drug abusers were practically non-existent and general hospitals were exceedingly reluctant to accept addiction cases.

One of the three principal recommendations of the Drug Commission was "To investigate the feasibility of creating a 24-hour emergency reception center to service all citizens in the County of Montgomery with a drug problem." Specifically, the Drug Commission indicated that the center should provide:

1. Immediate medical and psychological care to drug abusers on a 24-hour basis,

2. Medical and psychological evaluations,

3. In-patient care from one hour to five days, and

4. Referral for appropriate treatment following the crisis services.

The inclusion of drug agency officials on the board resulted in a decision to consider expanding emergency psychiatric coverage to include drug detoxification services. The Drug Commission study had documented that the county was experiencing a heavy growth in substance abuse and a concomitant need for services. Additionally, the public and county officials were clearly interested in alleviating these problems.

Once the decision was made to provide detoxification to drug users, it was recognized that alcohol detoxification also should be available. The police were particularly interested in phasing out "drunk tanks." Furthermore, a long-term alcohol rehabilitation program had recently been established in the county. This program had funds available for detoxification and agreed to commit them to the Montgomery County Emergency Service since it would be more efficient to have all emergency services under one roof. It would then serve as an appropriate subsequent placement.

By 1972, the concept of a temporary emergency psychiatric facility had developed into a design for a comprehensive emergency unit serving individuals experiencing mental health, mental retardation, drug, and alcohol crises. As one board member recalls: *It was fascinating to see the evolution of a stop-gap solution to meet a state mandate progress to a design that the county really desperately needed. It wasn't until we had arrived at the final design that we realized here is something Montgomery County must have. And at this crucial point we had the wholehearted support of the community and the county officials."* The respective Boards of Directors of the County Mental Health/Mental Retardation Office and the County Drug and Alcohol Council had agreed to provide financial support. Funds were secured from these three county governmental organizations and from LEAA through block grants made available by the Pennsylvania Governor's Justice Commission. Implementation was scheduled for the fall of 1972.

Difficulties arose, however, in locating a facility, which delayed the opening of MCES for over a year. Three alternatives were considered: (1) space in a general hospital, (2) construction of a new facility, and (3) space in Norristown State Hospital. Several general hospitals were approached but their responses were negative. Construction of a new facility was never a serious alternative since the cost would be exorbitant. Norristown State Hospital, similar to many state mental institutions, was experiencing a decrease in population due to the national trend of deinstitutionalization. Moreover, it was located in the county seat and was thus conveniently close to the county courthouse for any necessary commitment hearings.* The Norristown State Hospital had a three-story building which had been recently vacated and could be readily renovated to comply with licensing standards and to accommodate MCES' requirements.

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* Commitment hearings are now held at MCES. However, prior to 1976, hearings were in the county courthouse; hence it was important to be within a reasonable distance.

In early 1973, arrangements were made with the proper state authorities to lease the building for one dollar per year. Dollar-a-year leases of unused state buildings are a common practice in Pennsylvania as elsewhere for agencies or nonprofit groups serving the public interest. Renovation costs ultimately were to exceed original projections because licensing criteria had become substantially more stringent for the re-occupation of an old building. However, the county government strongly backed the development of an emergency service unit and agreed to pay the renovation costs of approximately $300,000. While funds could have been secured from the Federal government or a private foundation, the financial support authorized by the County Commissioners indicates the solid support that the emergency service concept engendered in Montgomery County.

A Medical/Executive Director, Dr. Angelo Zosa, was hired by the board in the fall of 1973 to begin the implementation of services, although the facility was not yet available for occupancy. Dr. Zosa, who still occupies this position, had previously administered an emergency psychiatric service as part of a private hospital-affiliated Base Service Unit, and had served as a consulting psychiatrist to another BSU. One of his first tasks was to meet individually with staff at local treatment programs and hospitals to acquaint them with proposed MCES capabilities and to learn about their services for eventual MCES referrals. Additionally, he met with criminal justice system personnel throughout the county to explain what types of cases MCES would be prepared to handle.

Preliminary interviewing and hiring of staff began, and arrangements for detoxification services were initially subcontracted with Eagleville Hospital, a long-term drug rehabilitation center. Dietary and laundry support were negotiated with Norristown State Hospital. A "hotline" was installed in temporary office quarters and arrangements made to utilize two beds at a local general hospital. These preliminary operations were carefully monitored to determine the most efficient procedures and effective service methods. In January of 1974, the MCES building was open for diagnosis and referral, and in February, emergency clients were admitted for in-patient treatment. Within the first year of operation state accreditation standards had been met and certification was approved by the Joint Commission on Accreditation of Hospitals (see Chapter 6 for a more complete discussion of accreditation procedures).

Clinical personnel attend a daily staffing session to discuss in-patient treatment plans.

2.2 Organization and Administration

The Montgomery County Emergency Service is located in Building 16 of the Norristown State Hospital. The building is a late Victorian brick structure that is situated next to playing fields and removed from the main buildings of the state hospital. "Building 16" has become synonymous over the years for Montgomery County Emergency Service. The building has been carefully restored to comply with licensing standards and to enhance the efficiency of intake, evaluation, and admission procedures. Design and decoration efforts have been made to minimize an institutional and hospital appearance.

MCES is a private, nonprofit corporation headed by a nineteen-member board of directors. The board represents a wide range of interests, including a township commissioner, police chiefs, the county district attorney, a public defender, hospital administrative officers, drug and alcohol program representatives, and private citizens. While not actively involved in the day-to-day operations of MCES, the board does take an active role in setting policy. More importantly, by virtue of their professional identifications, board members were instrumental in developing for MCES initial liaisons with the community and its agencies. The board convenes monthly and reviews major administrative, clinical, and financial developments. Additionally, the board is responsible for hiring the Medical/Executive Director and the Administrator.

Figure 2.1 indicates the organizational structure of the Montgomery County Emergency Service. The overall operation of MCES is supervised and conducted by the Medical/Executive Director and the Administrator. Each of the two executives is also responsible for specific aspects of the organization. The primary functions of the Medical/Executive Director are to coordinate and assist in the direction and delivery of all medical and auxiliary services. As a psychiatrist, he provides psychiatric services to patients and supervises and consults with other MCES psychiatrists and clinical staff. He also directs the daily staff meetings in which each in-patient case is discussed. The Medical/Executive Director also chairs several in-house committees and represents the hospital in various community endeavors. Finally, he is often required to provide expert testimony at involuntary commitment hearings for MCES patients.

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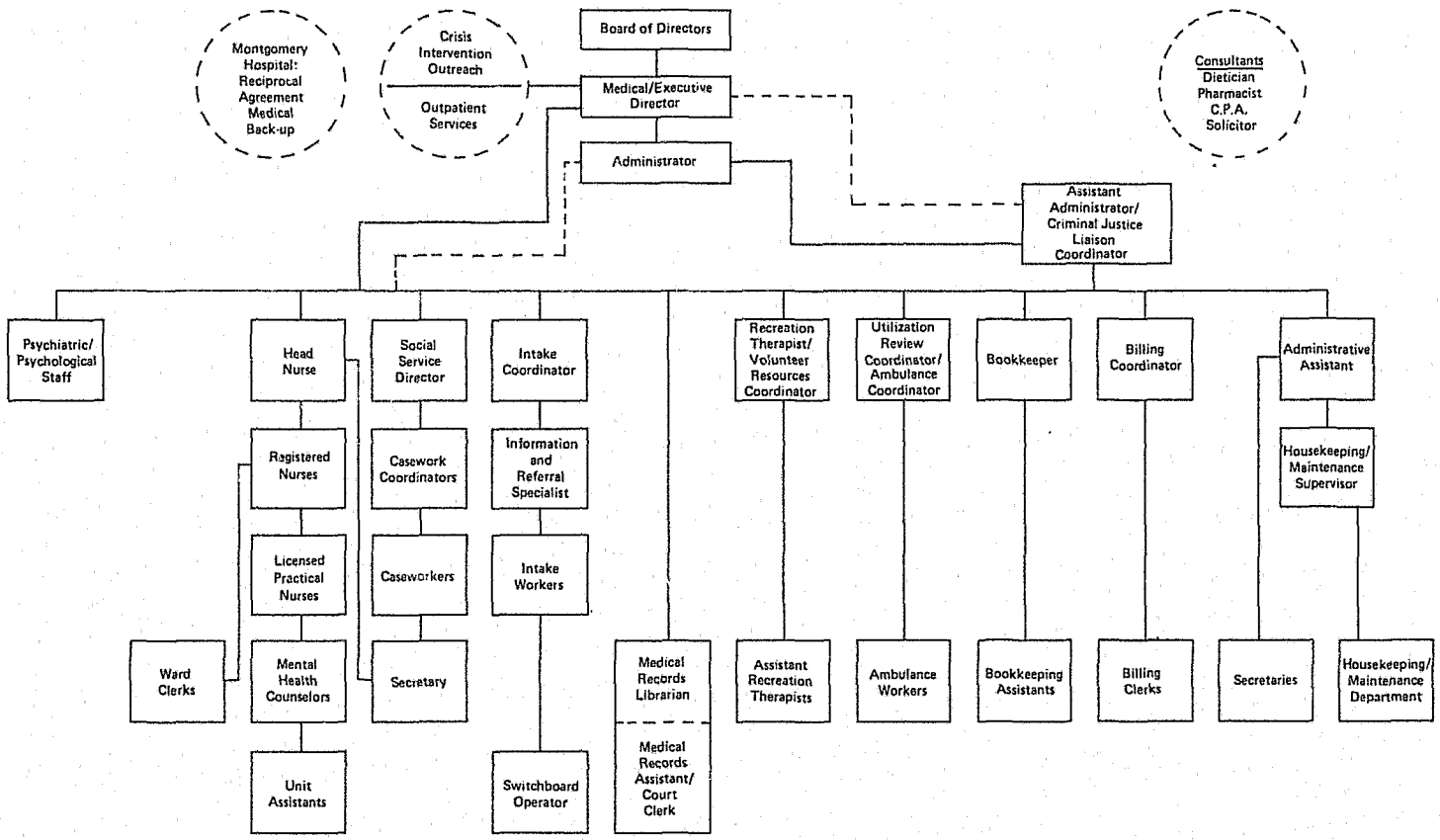
Figure 2.1
Organization Chart
Montgomery County Mental Health/Mental Retardation Emergency Service, Inc.



The MCES Administrator, Dr. Naomi Dank, is an experienced hospital administrator with a degree in mental health administration. She is responsible for the business management of the program. It was through the Administrator's office that third party billing procedures were instituted. Currently, over 97% of the hospital budget is supported through third party billings such as Medicare, Medical Assistance and private insurance arrangements (a full discussion of the procedure can be found in Chapter 6). The Administrator is also responsible for grants management and chairs various in-house committees.

The Criminal Justice Liaison Coordinator, who is currently serving as Assistant Administrator, is responsible for informing criminal justice personnel in the community about the availability and limitations of the emergency service program (a detailed review of these activities is presented in Chapter 5). He is responsible for research and evaluation efforts and supervises six students on practicum who are stationed as human service worker trainees in selected county police stations.

Administrative staff and support personnel, secretaries and billing clerks, work during the week from 8-4. Clinical professionals and supporting staff work a rotating schedule to provide patient services seven days a week, 24 hours a day. Clinical and supporting staff consist of the following full- and part-time staff: telephone intake personnel, psychiatrists, registered nurses, licensed pratical nurses, psychologists, social workers, caseworkers, a Volunteer Resources Coordinator, recreation therapists, mental health counselors, ambulance staff, ward clerks, and unit assistants. These personnel staff the MCES hospital on a 24-hour basis in the following shift pattern:

8-4

2 Intake Telephone Workers
2 Social Workers
3 Psychiatrists
1 Psychologist
3 Casework Coordinators
5 Caseworkers
2 Mental Health Counselors
1 Head Nurse (RN)
1 RN
1 Ambulance Coordinator/ Utilization Review Coordinator (RN)
1 LPN
1 Volunteer Resource Coordinator
2 Recreation Therapists
3 Ambulance Workers
3 Unit Assistants
1 Ward Clerk
1 Receptionist

4-12

2 Intake Telephone Workers
1 Psychiatrist
4 Mental Health Counselors
2 RNs
3 Ambulance Workers
2 Unit Assistants

12-8

2 Intake Telephone Workers
1 Psychiatrist
3 Mental Health Counselors
1 RN
1 LPN
3 Ambulance Workers
3 Unit Assistants

The current staff represent a variety of backgrounds. The professionally designated positions (psychiatrist, psychologist, RN, LPN) are filled by persons with the requisite degrees, while the remaining staff range from persons with master's degrees to ex-offenders, ex-addicts and recovered alcoholics. Although the organization of MCES is administratively structured as a psychiatric hospital, there is extensive use of non-degreed counselors similar to the models employed in drug and alcohol rehabilitation centers. (Typically, rehabilitation facilities are staffed by ex-addicts or recovered alcoholics.)

Volunteers are used to a limited extent at MCES. The Volunteer Resources Coordinator, who is also responsible for recreational therapy and supervises the recreation therapists, recruits, trains and assigns volunteers to jobs. Volunteers are often friends or relatives of staff or former MCES patients. Volunteers typically help organize recreation activities for patients or assist in clerical tasks.

The use of professional personnel with non-degreed counseling personnel is believed to enhance the evaluation and treatment process. Counselor positions include telephone intake workers, mental health counselors, caseworkers, and unit assistants. Individuals in each of these positions have direct interaction with clients ranging from simply "rapping" to counseling patients and families and obtaining personal information on the clients. Opportunities for advancement in responsibilities and client interaction are provided through training sessions and educational leave. Conscious efforts are made by professional staff to allow counselors to work with clients (under their direction at all times) and to involve them in the treatment process. As one professional staff member explains, *"Patients often feel more comfortable talking to a counselor. They may open up to the counselor in a very different manner than they relate to a doctor or other professional whom they may view as authority figures. Not only are we providing the patient with someone to 'rap' with but we may learn some valuable information. Finally, it allows all of our staff to feel really involved in what we're doing."*

Chapter 3: Civil Commitment

All MCES patients are either voluntarily admitted or involuntarily *committed* to treatment. With regard to the latter, this obviously necessitates a certain curtailment of individual rights and as such requires close scrutiny. The justification by which these rights are temporarily curtailed is not the state's police power, which allows for the incarceration and concomitant suspension of many individual rights of convicted offenders. Rather, to curtail the rights of such persons as MCES patients, the state's ability is derived from the notion of *parens patria* which dictates that the state is a sovereign and retains sovereign power of guardianship over persons under a disability, such as minors, incompetents and insane persons. The method by which civil rights are suspended for persons who suffer mental disability is civil commitment. All states have some form of commitment statute which governs the process. Civil commitment in Pennsylvania is governed by the Mental Health Procedures Act of 1976 which is indicative of the current national trend (set by recent Supreme Court decisions) toward sensitivity to constitutional due process requirements for mental health commitments. Specifically, the law is highlighted by the requirement that the state show a *clear and present danger of bodily harm to oneself or others* before involuntary commitment can be authorized and, upon such a finding, that commitment be by *the least restrictive alternative possible*.

This chapter will present a brief synopsis of the Pennsylvania law to provide replicators with the statutory background against which the MCES services are provided and to demonstrate the manner in which the more common statutory provisions are implemented.

3.1 The Mental Health Procedures Act of 1976

The Mental Health Procedures Act of 1976 governing civil commitment in Pennsylvania is a comprehensive revision of the voluntary and involuntary commitment procedures which were previously in force under the Mental Health and Mental Retardation Act of 1966. The current Act's statement of policy (Section 102) succinctly states the legislative intent and illustrates its sensitivity to constitutional due process requirements for mental health commitments.

> Section 102. State of Policy
>
> It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness.

The Act provides for two kinds of commitment, voluntary and involuntary. In either case, the Act requires individualized treatment plans with a mandatory 30 day review by a clinical psychologist or physician. Section 201 sets forth the following guidelines for voluntary commitment:

- Any person 14 years of age or over who substantially understands the nature of voluntary treatment can apply for examination and treatment.
- A parent, guardian, or person standing in *loco parentis* to a person less than 14 years of age can make an application for treatment.
- The application can be made to the County MH/MR Administrator or an approved facility (such as MCES).

- A person can withdraw from voluntary treatment upon delivery of a written notice to the facility or can remain for a period not to exceed 72 hours after having given written notice of intent to withdraw.

Emergency involuntary commitments are governed by Section 302, and are limited by that section to persons who are severely mentally disabled and in need of immediate treatment. A person is "severely mentally disabled" when he or she is so incapacitated by mental illness that there is a clear and present danger of harm to himself or others. Such commitments are only effected after an emergency examination, which must be conducted by a physician, has been authorized by the County Mental Health Administrator or his delegate or requested by a police officer or physician. One such delegate is always on duty at the MCES intake office. Examinations are authorized only on petition of persons who have observed (and sworn to that effect) the party in question act in the statutorily prescribed manner within the preceding 30 days. Based on the information presented in the petition, available corroboration, and personal observation, the delegate determines whether an emergency evaluation will be conducted. Persons who are taken to designated facilities (MCES is the only designated facility in Montgomery County) for examination must be examined within two hours. Such examinations may result in up to 72 hours of involuntary emergency treatment.

The authorization of emergency examination and treatment automatically lapses after 72 hours. Section 303, however, provides for a hearing within those 72 hours for the purpose of extending the period to a maximum of 20 days. An application for an extended 20 day period of treatment may be filed in the court of common pleas for any person then in emergency treatment when the attending psychiatrist determines that the need for treatment will extend beyond 72 hours.

When the court receives the application, counsel is appointed for the person, and an informal hearing is held at the facility by a mental health review officer (an attorney appointed by the court) within 24 hours. The MCES Board Room in Building 16 is used for these hearings. In Montgomery County two hearing officers (both experienced lawyers with backgrounds in civil commitment) have been appointed by the District Court to hear all such hearings and

have therefore developed a particular expertise.* Moreover, to insure the protection of patient rights, the County Public Defender's Office (which also is represented on the Board of Directors) has appointed one full-time counsel to handle all such hearings. If the person is certified to undergo the 20 day period of treatment, the person shall have the right of review by the court of common pleas within 72 hours of the certification. At the expiration of 20 days, the person shall be released unless he is admitted to voluntary treatment or the court orders a full-term 90 day period of treatment.

Section 304 of the Act provides that a person who is severely mentally disabled may also be subject to court-ordered involuntary treatment whether or not he or she is being held under the emergency section. Such treatment can only be ordered after a full hearing at which the party retains the right to counsel and which is governed by the normal rules of evidence and criminal procedure. The standard for commitment under Section 304 is "clear and convincing evidence that the person is severely mentally disabled and in need of treatment."** If the court finds by clear and convincing evidence that the person is severely mentally disabled and in need of treatment, the court will order a 90 day commitment. In-patient treatment will be ordered only after less restrictive alternatives have been reviewed and deemed inappropriate. The treatment period shall not exceed 90 days unless the person has committed acts giving rise to serious criminal charges, or has been found incompetent to be tried, or has been acquitted by reason of insanity. In these cases, the person may be ordered to undergo treatment for one year.

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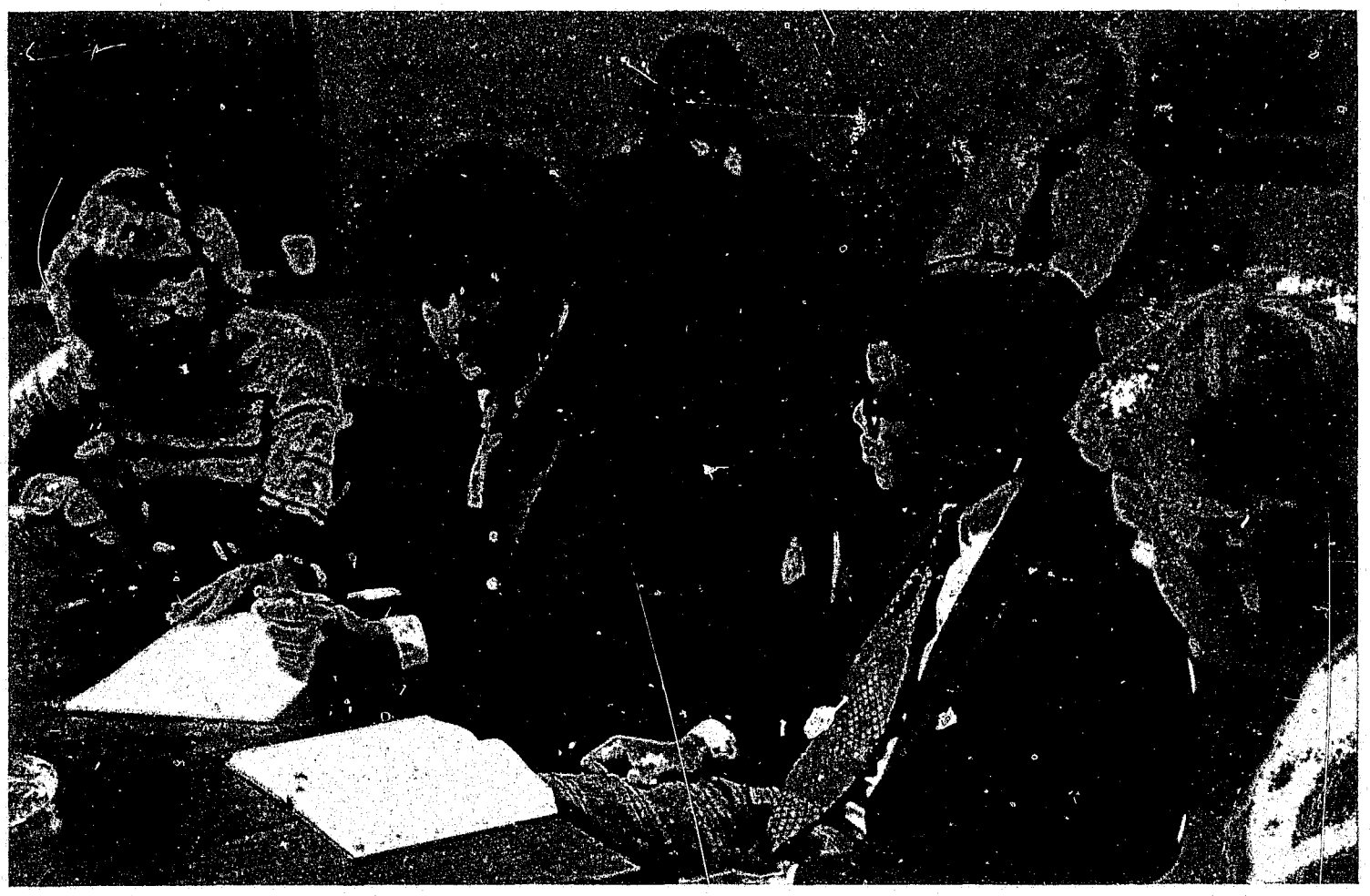
* The need for hearing officers was necessitated by the increase in the number of civil commitment cases brought about by the Act of 1976, and resulting burden on the court's calendar. The primary reason that the new Act resulted in an increased number of hearings is that it reduced the allowable detention for emergency treatment from 10 to 3 days. Thus, if the attending doctor feels, after the initial 72 hours have expired, that the patient still requires treatment, a 303 hearing must be held.

** No case law has yet developed to indicate how "clear and convincing" relates to the civil "preponderance of the evidence" or criminal "reasonable doubt" standards.



Represented by a County Public Defender, a female patient listens to testimony provided by the Medical/Executive Director and a District Attorney at a commitment hearing.

Section 403 of the Act provides that whenever a person who is charged with a crime, or is undergoing sentence, is or becomes severely mentally disabled, proceedings for obtaining treatment are to be instituted in the same manner as if he were not so charged or sentenced, although such proceedings will not affect the condition of any criminal detention. As a result, arresting officers may bring an individual to MCES for evaluation and possible treatment while still instituting charges. Although such charges may be dropped at a later time, there is no requirement that they must be dropped before MCES can accept a patient.

The remaining sections of the Act deal with incompetency and pleas of insanity. Since neither have any direct bearing on MCES operations they are omitted here. However, for comparative purposes, the Act can be found in its entirety in Appendix A.

3.2 Involuntary Commitment

Voluntary commitments (201) do not present much of a legal problem. Of course, before any person is accepted for voluntary treatment he must give his consent to the proposed treatment and to any restriction which may be imposed upon him. Also, as the statute indicates, persons in voluntary treatment may withdraw at any time by giving written notice, unless they have agreed in writing at the time of their admission that release can be delayed for 72 hours following such notice. Often, police will bring cases to MCES who, at arrival, are willing to commit themselves voluntarily. In fact, all patients are given the choice. However, when an enforcement agency is involved in bringing the patient to MCES, the intake worker and/or police officer will usually insist that the patient provide 72 hours' written notice prior to leaving.

Involuntary commitments present a different problem. MCES is the single designated facility in the entire county with authorization to perform evaluations for involuntary emergency treatment as provided in the statute. Since the majority of evaluations must be approved by the County Mental Health Administrator's Office, that office has sworn in at least one MCES intake worker per shift as a delegate of the administrator's authority. If a potential patient refuses voluntary treatment it is the delegate's decision as to whether an evaluation should be ordered under the provisions

of Section 302. Often, police will call the delegate intake worker, describe an incident and/or individual, and inquire as to whether the delegate will, under these facts, determine if an evaluation is indicated. Of course, the delegate cannot guarantee commitment; this can only be accomplished by the evaluating physician. Most problems concerning involuntary (302) commitment involve the clear and present danger clause. Obviously, this clause is open to interpretation; and often to the dismay of police officers, their opinion may differ from that of the examining physician. It is the physician, however, who has the final authority for purposes of commitment in deciding which acts or threats constitute a clear and present danger to the patient and those around him or her, and this decision can only be made after an evaluation interview has been completed. Consequently the telephone worker can only advise that a patient be brought in for an evaluation.

In response to many requests by police, the delegate's office has prepared the following examples of two typical calls that would probably <u>not</u> be subject to involuntary commitment.

A. A person who is wandering alongside the road and appears dazed and confused but openly hostile to commitment.

B. A person "prowling" around someone's home, a cemetery, or other inappropriate place and becomes belligerent when confronted with commitment.

In the first instance, the key factor may be that the person was wandering <u>alongside</u> the road, thus not really endangering anyone. If the person were <u>in</u> the road obstructing and interfering with traffic, however, it might be interpreted that he was not only endangering himself but also the lives of unsuspecting motorists. In the second case, the person may appear suspicious and may be in fact causing someone alarm by his behavior; but unless specific threats were made or harmful acts committed, this person would most likely not be admitted involuntarily.

On the other hand, most persons exhibiting violent, destructive, aggressive and/or threatening behavior will probably be approved for an evaluation under Section 302. However, for any involuntary commitment to be approved, the petitioner is required to have personally witnessed the dangerous behavior or threats and must sign

a written statement in which such acts are outlined in detail. As noted earlier, however, those acts which constitute a clear and present danger are open to interpretation. Consequently, only if the statement of the petitioner and the judgment of the doctor coincide can someone be committed against his will.

The statute requires that before an involuntary commitment can be effected, a responsible person must swear to having witnessed conduct that would meet the "clear and present danger" test. The intake worker must exercise judgment not only in the events described (Do they meet the test?); he must also make a threshold judgment (Are they a fair representation of the facts?). A recent and not uncommon incident illustrates the point: The intake worker received a call from a woman who alleged that her husband beat her with a hammer, had recently attempted to drown her in the bathtub and ate cigarettes. This seemed like a potential commitment and the intake worker asked the woman to bring in her husband. She came in later, alone, saying he refused. She was asked to draft a sworn statement and after balking a bit, did so. However, the story changed somewhat in the transcription. The hammer became a fist (she did come in with a slight bruise) and the bathtub incident became an attempted strangulation in the shower. Still, however, the story remained substantially the same, less the hyperbole that might accompany an hysterical phone call. Nevertheless, enough discrepancies existed to ask her for corroboration--the phone number of witnesses or other family members. This is a common question that often results in frantic explanations of their non-existence and a decision to "think things over for a while." However, this woman provided the worker with her daughter's number. Although the daughter was not immediately available the telephone worker persisted and finally reached the daughter. It was then discovered that, in fact, the couple were on the verge of a divorce having been separated for over a year. The cause of the split was the wife's alcoholism. She was afraid that by a settlement her husband would end up with their house and had therefore fabricated this story to commit him and retain the house.

The important lesson for replicators is the need for care, corroboration, and perhaps even a good intuition in the intake office.

If patients are involuntarily committed, the Pennsylvania law requires they be read a statement of their immediate rights and that a Bill of Patient Rights be posted. Because they are somewhat

unique and perhaps useful to replicators, these provisions of the Pennsylvania law are reproduced here. The following explanation of rights is read to all MCES patients under involuntary emergency commitment (302).

You have been brought to Montgomery County MH-MR Emergency Service because a responsible person has observed your conduct and feels that you present a clear danger to yourself or to other people. Within two hours from now you will be examined by a physician. If you are not admitted here, you will be returned to whatever place you desire within reason. If the examining physician agrees that you are clearly in danger of harming yourself or someone else, you will be admitted to this facility for a period of treatment of up to 72 hours. While you are here, you have the following rights:

1. *You must be told specifically why you were brought here for emergency examination.*
2. *You may make up to three completed phone calls immediately.*
3. *You have the right to communicate with others.*
4. *You may give to the facility the names of three people whom you want contacted, and they will contact them and keep them informed of your progress while here.*
5. *The County Mental Health Administrator must take reasonable steps to assure that while you are detained, the health and safety needs of any of your dependents are met and that your personal property and your premises where you live are looked after.*
6. *You need not consent to any treatment other than treatment necessary to protect your life or health or to prevent you from physically injuring others.*
7. *When you are no longer in need of treatment or in 72 hours, whichever comes sooner, you will be discharged unless you agree to remain here voluntarily or unless the director of the facility asks the court to extend your treatment here.*

In addition to the above rights, while you are a client at this facility, the attached Bill of Rights applies to you. You will receive a longer more detailed version of Department of Public

Welfare Regulations on rights within 72 hours after your commitment. If you do not understand these rights, your (mental health counselor) will be pleased to explain them further to you.

In addition, the following "Patient Bill of Rights" is posted in all prominent areas.

BILL OF RIGHTS presented to patients after initial 72 hour treatment phase:

YOU SHALL RETAIN ALL CIVIL RIGHTS THAT HAVE NOT BEEN SPECIFICALLY CURTAILED BY ORDER OF COURT.

1. *You have the right to unrestricted and private communication inside and outside this facility including the following rights:*

    a. *To peaceful assembly and to join with other patients; to participate in or organize a body of patient government when patient government has been determined to be feasible by the facility.*

    b. *To be assisted by any advocate of your choice in the assertion of your rights and to see a lawyer in private at any time.*

    c. *To make complaints and to have your complaints heard and decided promptly.*

    d. *To receive visitors of your own choice at reasonable hours unless your treatment team has determined in advance that a visitor or visitors would seriously interfere with your or others' treatment or welfare.*

    e. *To receive and send unopened letters and to have outgoing letters stamped and mailed. Incoming mail may be examined for good reason in your presence for contraband. Contraband means specific property which entails a threat to your health and welfare or to the hospital community.*

    f. *To have access to telephones designated for patient use.*

2. *You have the right to practice the religion of your choice or to abstain from religious practices.*

3. *You have the right to keep and to use personal possessions, unless it has been determined that specific personal property is contraband. The reasons for imposing any limitation and its scope must be clearly defined, recorded and explained to you. You have the right to sell any personal article you make and keep the proceeds from its sale.*

4. *You have the right to handle your personal affairs including making contracts, holding a driver's license or professional license, marrying or obtaining a divorce and writing a will.*

5. *You have the right to participate in the development and review of your treatment plan.*

6. *You have the right to receive treatment in the least restrictive setting within the facility necessary to accomplish the treatment goals.*

7. *You have the right to be discharged from the facility as soon as you no longer need care and treatment.*

8. *You have the right not to be subjected to any harsh or unusual treatment.*

9. *If you have been involuntarily committed in accordance with civil court proceedings, and you are not receiving treatment, and you are not dangerous to yourself or others, and you can survive safely in the community, you have the right to be discharged from the facility.*

10. *You have a right to be paid for any work you do which benefits the operation and maintenance of the facility in accordance with existing Federal Wage and Hour Regulations.*

Chapter 4: Services

A distraught teenager threatening suicide is calmed by a midnight telephone conversation. An angry man barricaded in his house with a shotgun agrees to accompany a psychiatrist to a hospital. A drug addict is detoxified for the first time and arrangements are made to transfer him to a long-term rehabilitation program. The parents of a juvenile alcoholic discuss their daughter's drinking problem with a psychologist and a mental health counselor.

The incidents described above illustrate the range and diversity of aid available through the Montgomery County Emergency Service. One of the unique strengths of MCES is that crisis intervention and emergency care are provided not only to individuals admitted as patients to the hospital. Recognizing that some crises may require immediate, on-the-spot attention, MCES can avert or stabilize such situations through a number of services including a telephone hotline, an ambulance equipped with life-saving devices, or a specially trained crisis intervention team. Centralization of emergency service delivery in one organization whose primary focus is crisis intervention and stabilization has provided the community of Montgomery County with comprehensive and efficient emergency care. This chapter examines the services and operations of MCES.

4.1 Patient Flow and Characteristics

Intervention services to clients are classified into three types: contact, evaluation, and admission. At the contact

stage, basic information is gathered concerning the individual's need for service. The information may be obtained on the telephone or by a personal interview conducted by intake workers. At this point a decision is made as to whether the individual should receive a psychiatric and medical examination and evaluation, or whether referral to another organization is more appropriate. The majority of contacts with MCES are referred elsewhere, since emergency aid is not warranted or needed. If evaluation is deemed necessary and the client is unwilling or unable to agree, and the situation warrants it, procedures are initiated for an involuntary examination and commitment for a period not to exceed 72 hours.

Upon completion of an examination which occurs immediately after the decision to perform one, the psychiatrist will either recommend in-patient admission to MCES or referral elsewhere for in-patient or out-patient treatment. Those individuals who have voluntarily requested admission may leave at any time within a 72-hour period or agree to remain at MCES for furtner care if necessary. In those instances involving an involuntary examination, a decision must be made whether to initiate proceedings to extend the commitment to 20 days. An extended commitment enables MCES to stabilize the patient's condition and to locate and secure a place for the client in a longer-term rehabilitation program or hospital. Frequently, however, patients admitted for involuntary evaluations will voluntarily request treatment beyond the 72-hour period, since after initial treatment services patients often become interested in seeking further treatment. In any case, referrals to continue the treatment processes initiated at MCES are always arranged.

MCES has recorded 11,374 client contacts, evaluations, and admissions, since February 1974 through May 1977. Approximately one-third of these clients are repeaters. Repeaters are generally individuals with mental health problems who may have stopped taking medication and a crisis is precipitated, or alcoholics or drug addicts who have suffered a relapse after initial treatment efforts.

An intake worker interviews a caller before deciding whether to recommend MCES services.

Table 4.1
Client Contacts
February 1974 to June 1977

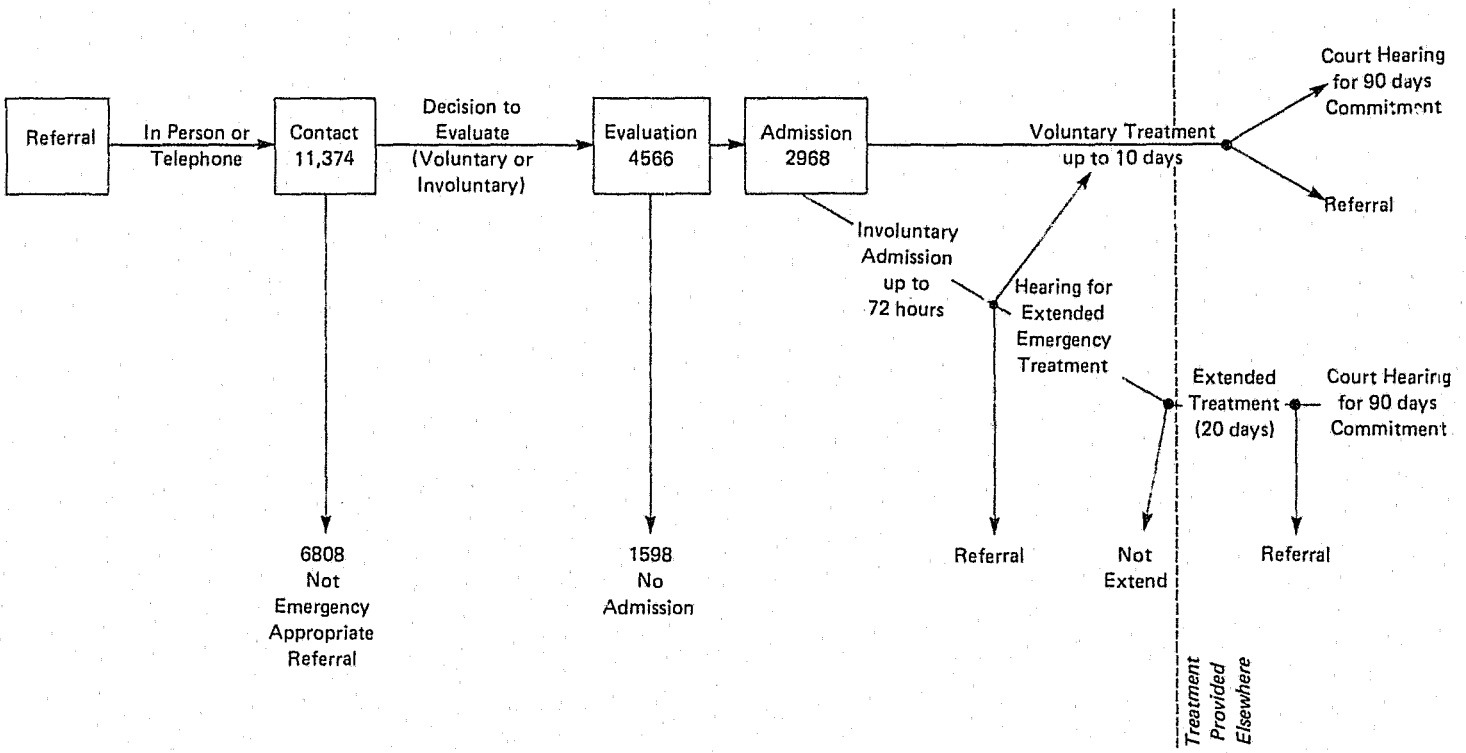
Type of Contact	Number	Percent of Total
Contacts only (walk-in or telephone consultation)	6,808	60%
Evaluations only	1,598	14%
Admissions only	2,968	26%
Total Clients	**11,374**	**100%**

The table above indicates the highest level of service received by each client. Thus, an individual counted in the admission category will have initially contacted MCES, proceeded to be evaluated, and ultimately accepted for in-patient services. Figure 4.1 on the following page depicts the flow of patients through MCES and also displays the attrition of patients at each level. Approximately one of every four contacts with MCES results in an admission.

The three-step screening process serves to ensure that individuals who are accepted for in-patient admission are clearly incapable of aiding themselves and are in need of immediate psychiatric or detoxification services. Individuals who contact MCES and are not referred for evaluation are generally people having psychiatric, drug, or alcohol problems that can best be treated at a BSU or other out-patient facility. Essentially, the level of severity of their problems is not seriously impairing their functioning or likely to create problems for those surrounding them. Approximately one-quarter of these contacts are initiated by police.

Any contacts who are suffering from severe physical problems are referred to general hospitals. Such individuals are treated for their physical problems and often referred again to MCES. An example of such a situation might involve an individual brought in by the police unconscious from a drug overdose. The police would be told to transport the individual to the nearest hospital with general emergency facilities. MCES would subsequently receive the person for detoxification services.

Figure 4.1
Patient Flow



Most of the clients who are evaluated but not admitted for in-patient treatment are individuals who voluntarily requested an examination. Typically, more than three-quarters of the clients evaluated voluntarily requested services. Their condition does not warrant admission and they are referred elsewhere for out-patient services.

The majority of admissions are also voluntary. In the first five months of 1977, 71 percent (325) of the admissions resulted from voluntary commitments. Generally, admitted patients are referred to MCES through self-referral, by family or friends, or through contact with criminal justice agencies. The majority of police referrals are individuals who have committed criminal acts that are drug or alcohol related. Other types of police referrals might include cases where individuals have committed criminal acts and exhibit exceedingly bizarre behavior during the arrest or arraignment process, or individuals who are discovered wandering the streets, seem to possess no address or social ties, and appear unable to understand what is occurring. Often, individuals in the latter category may be out-patients receiving treatment elsewhere for a mental condition and have stopped taking their medication. MCES is able to intervene before their situation further deteriorates.

Over one-half of MCES admissions are patients with mental health or mental retardation problems. Table 4.2 displays admissions

Table 4.2
Montgomery County Emergency Service Admissions: January to June 1977

Commitment \ Emergency Problem	Mental Health/ Mental Retardation	Drug/Alcohol	Total
Voluntary	189	136	325 (71%)
Involuntary	121	12	133 (29%)
Total	310 (68%)	148 (32%)	458 (100%)

by emergency problem and by commitment. Mental health and mental retardation cases accounted for 68 percent of the in-patient caseload from January to June 1977. Admissions range in age from teenagers to elderly patients in their 80's. Drug abusers are generally youthful and involve only a small proportion of admissions. The majority of admissions--alcohol abuse, mental health, and mental retardation cases--are fairly evenly distributed in age range. Whites comprise 84 percent of the admissions. While only 16 percent of the admissions are for non-whites, the non-white population of Montgomery County is only 4 percent. The relatively high proportion of non-white admissions is believed to be due partially to the location of MCES in Norristown, which is the only urban area in Montgomery County and has a large population (17 percent) of non-whites.

Building 16 is open 24 hours a day, seven days a week, thus enabling MCES to intervene in emergency situations and to provide treatment around the clock. MCES has found that emergencies do occur on a 24-hour basis throughout the week. Weekend contacts, evaluations, and admissions comprised 27 percent of the individuals served in a seven-month period. Moreover, crisis situations are not confined to normal working hours. The day shift (8 a.m. to 4 p.m.) had contact with 41 percent of the clients served, while the 4 p.m. to 12 midnight shift provided services to 45 percent of 1,721 clients in the seven-month period. Finally, 216 individuals (13 percent) were in need of MCES' resources in the middle of the night or early morning during the midnight to 8 a.m. shift. Clearly, Building 16 has demonstrated the need in Montgomery County for 24-hour availability of emergency psychiatric and detoxification services.

4.2 Overview of Operations

The Montgomery County Emergency Service is equipped to handle urgent psychiatric situations such as suicidal behavior; depression; agitated, confused, aggressive, or fearful mental states; family crises; and other situations where immediate evaluation and intervention can effectively minimize the risk to the patient and to those around him. Drug or alcohol problems that the Emergency Service commonly deals with are acute intoxications, withdrawal states, and addictive problems with serious social or

psychiatric complications. While a large number of the contacts that MCES receives are not ones warranting evaluation or admission, every effort is made to ensure that clients, regardless of intervention level, are referred elsewhere for continuing treatment or services.

Arrangements for longer-term care and intervention are a primary concern at MCES. Recognizing that emergency services can only stabilize a patient's obvious crisis and symptoms, clinical staff attempt to assess the individual's motivation and attitude towards rehabilitation. Family members are often interviewed by telephone or asked to come in so staff can gain an understanding of the family environment and the client's interactions within the family. In addition, any other agencies or doctors that previously have treated a client are contacted to gain information on the treatment modality and its effect. In instances where a client's problem appears to be due to significant external causes such as lack of employment, finances, proper housing, etc., public agencies and community organizations that can resolve such situations are contacted. Ultimately, it is hoped that the program or hospital where the patient is referred offers the most appropriate treatment approach or services for that individual's personality and condition.

Suitable referrals are clearly an important factor in preventing further emergency or crisis situations. Nevertheless, MCES recognizes that some patients are not adequately motivated to pursue out-patient therapy, or willing to remain for a proper length of time in an in-patient facility whether voluntarily or involuntarily committed, or are simply "revolving door" clients. Such individuals, however, are still free to receive MCES services whether it be another referral or crisis intervention.

While MCES interactions with clients may range only from several hours to a few days, comprehensive patient diagnosis and preparation for aftercare are considered to be the essential components of a truly effective emergency service. Moreover, the fact that MCES serves a diversified population that may range from an elderly mentally retarded person to a juvenile drug abuser is regarded as a distinct advantage for several reasons. As the Medical Director explains:

Since MCES is a multi-service emergency facility, we are not committed to one form of treatment, and because of our diverse clientele, we have an equally diverse staff. For example, a person with psychiatric problems will not be treated solely by staff trained in psychiatry but will have contact with other professionals and counselors whose backgrounds range from degrees in psychology and social work to ex-addicts and ex-offenders. Frankly, we feel that the balanced distribution in our staff composition helps us conduct a comprehensive assessment of a client's problems that is not focused exclusively on alcoholism or some other obvious cause as the source of his difficulties.

The capability to provide comprehensive evaluation and treatment to individuals undergoing critical psychiatric, alcohol, or drug crises is enhanced by the fact that MCES is able to intervene directly on the scene. Immediate intervention can avert the escalation of a potentially dangerous situation and perhaps prevent the necessity for subsequent in-patient treatment. The multiple emergency capabilities of MCES--hotline, transportation, evaluation, in-patient care, crisis intervention team, and criminal justice liaison--ensure the community of emergency services readily accessible to all at any time.

4.2.1 Emergency Telephone Service

The Emergency Telephone Service is designed to serve as the entry point for access to MCES services. It is located in the intake room which is where all clients are brought for initial information collection and where evaluation decisions are made. The telephone is staffed seven days a week, 24 hours a day. Each shift consists of an intake worker and a county mental health delegate, who is responsible for deciding and preparing the necessary paperwork on involuntary examinations.

The phone service is intended to be primarily a "hotline" for the Montgomery County social services community and police departments. It is available to the general public but is not advertised nor publicized as a general emergency number. If a private citizen

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were to call a phone operator for an emergency number (the county has no 911 system), that person would likely be referred to either the police, a BSU, or other service provider. An individual from one of these organizations would then telephone MCES if its services were deemed appropriate. Since BSUs are open only during normal working hours, anyone calling a BSU number after closing will hear a recorded message referring them to MCES for any problems requiring immediate attention.

Police or other criminal justice personnel, as well as staff from medical and social service agencies, are encouraged to call MCES prior to bringing patients or requesting transportation to MCES. This accomplishes three objectives. First, it familiarizes those personnel with the phone service, increasing the likelihood that they will call for advice in handling situations that might require MCES assistance or a referral. Second, since the telephone is staffed at all times by a county mental health delegate, he can alert the psychiatrist on duty that it may be necessary to perform an evaluation. While the decision to perform an evaluation cannot be made over the phone, facts may be reported over the phone which indicate that an evaluation is warranted and that the individual should be brought to MCES. Finally, the initial phone contact allows the staff to arrange transportation if the emergency ambulance is needed.

While the "hotline" has not been advertised, publicity of MCES activities in local papers and general community knowledge has led over the years to an increasing number of contacts from the general public. In some instances, individuals are simply interested in "rapping" and are referred to other "hotlines" that offer rapping and counseling services over the phone. Other contacts are individuals with legitimate emergency problems, and staff can collect basic data over the phone and arrange transportation if necessary. Occasionally, callers are potential suicide victims or in the throes of violent situations, and staff have been trained to handle such calls.

Emergency Telephone staff are responsible for screening all contacts. Typically, the initial contact is by telephone and then the client meets with a staff member in person. Basic information is gathered on each contact whether the case simply involves a telephone referral or an interview and subsequent evaluation.

Demographic and employment data are requested and a description of the emergency situation noted. (A copy of this form is included in Appendix B.)

> *Anthony J. has been arrested for vandalism and criminal trespass. This is a first arrest for the 19 year old. Released on bail to his father, a violent argument soon occurs at home over Anthony's lack of employment and recent arrest. Fearing the consequences as the two come to physical blows, Anthony's father calls the local police department for help. The police officer on duty suggests that he telephone MCES. A MCES intake worker talks to Anthony's father, who asks if he can commit Anthony, claiming that he is perpetually troublesome and violent. The intake worker requests that the family come in for an interview. During the interview, it is discovered that Anthony has become depressed from a long and unsuccessful job search, which has in turn led to significant drinking habits. While Anthony appears to have a drinking problem, he is sober at the time and coherently describes his arrest and current situation. He is referred to an out-patient treatment program for teenage alcoholics, and the parents are advised to seek counseling at their local BSU.*
>
> *James A. is transported to MCES by the Norristown Police Department. Numerous complaints from neighbors about his bizarre behavior and incoherent speech have brought him to MCES. The officer who investigated the complaints was assaulted by James. Throughout the interview, James is extremely agitated, appears to be delusional, and is unable to answer questions. The County Mental Health Delegate decides that an involuntary evaluation is necessary. The police officer who was assaulted signs the petition. James is informed of his rights and advised that he may make three telephone calls before he is examined by a psychiatrist.*

Evaluations are typically recommended for contacts who are acutely agitated, suicidal, hallucinating, or psychotic, or are suffering from extreme intoxication or drug abuse. A county mental health

delegate, available 24 hours a day, is responsible for ensuring that the forms necessary for either voluntary or involuntary commitments are completed and for informing clients regarding the implications of hospitalization and their rights.

4.2.2 Emergency Evaluation

MCES is the only designated agency in Montgomery County where evaluations for involuntary commitments may be performed. While a majority (65 percent) of the evaluations conducted result in admission to MCES, the remainder are often necessary to determine a proper course of action. Initial evaluations of a patient's condition are made by emergency intake staff and then passed on to the psychiatrists on duty. A psychiatrist is always available to provide supervision to intake staff and to decide whether a patient requires admission to the in-patient unit or referral elsewhere.

> *Bob R. presented himself at the MCES intake office early one morning. He had learned of MCES services through a friend. In the interview with the intake worker, he stated that he was on tranquilizers prescribed by a family physician because, by self-description, he was a really "uptight and rigid kind of guy." Bob said he had used drugs occasionally but was now concerned about the fact that he was extremely depressed and was starting to use drugs on a daily basis. The intake worker suggested that Bob receive a psychiatric evaluation, which he agreed to. The psychiatrist who examined Bob decided that out-patient therapy in a group setting with other drug abusers would be appropriate treatment. Bob was pleased with the notion of discussing his problems with others who had similar experiences. An appointment with the appropriate agency was made for Bob for that afternoon.*

4.2.3 Short-Term In-Patient Care

Anna S. was brought to MCES in a severely intoxicated state by a next-door neighbor in her apartment building. Recently widowed, Anna's drinking had become noticeable to her neighbors in the past few weeks since her husband's death. Once she was detoxified, Anna requested to remain at MCES beyond the 72-hour limit. From individual and group therapy counseling sessions, it became clear that Anna was aware that she was an alcoholic and was concerned about her problem. After extensive discussions with a psychologist and a mental health counselor, Anna decided to go to a longer-term in-patient treatment program, since she did not yet feel capable of combatting her alcoholism as an out-patient. MCES arranged for her social security checks to be forwarded and for a neighbor to watch her apartment.

While MCES is primarily an emergency facility with an emphasis on diagnosis and referral, it does have the capacity to provide short-term in-patient care. The 24-bed in-patient unit, including four security rooms (security windows and locked doors), is fully staffed with professional personnel. The nursing staff includes around-the-clock registered nurses, licensed practical nurses, mental health counselors, and unit assistants. Each shift is supervised by a Head Nurse.

The average length of patient bed occupancy is 5.8 days. In this time, an in-depth evaluation is performed, immediate medical and psychiatric needs are dealt with, and a referral for long-range treatment and/or follow-up care is arranged. Patients with serious medical problems are transferred to a local general hospital with which MCES has a reciprocal agreement, and are returned to MCES upon discharge.

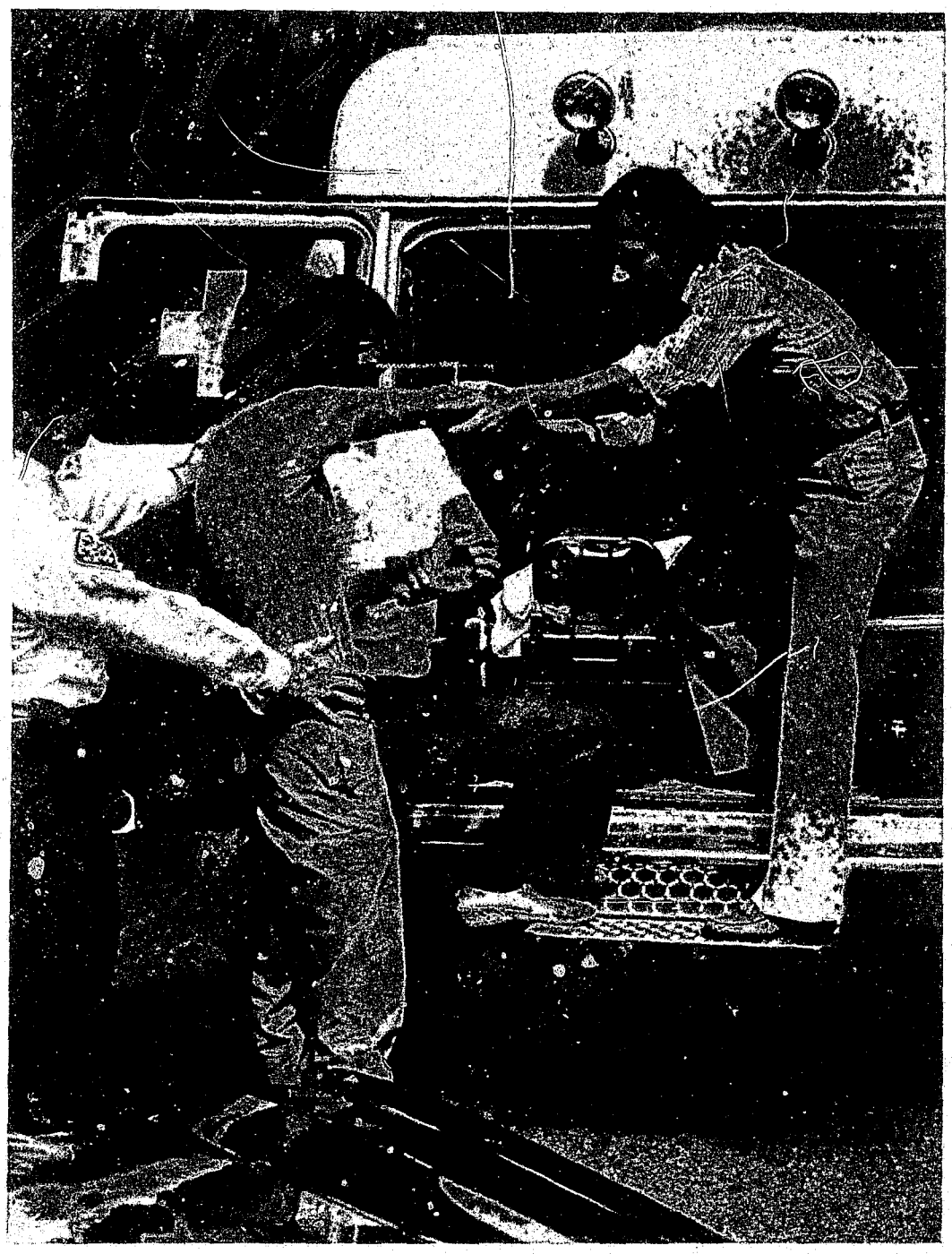
While stabilization of patients' emergency conditions and treatment arrangements are primary objectives, MCES staff work with patients on an individual basis to encourage their motivation for rehabilitation, and to aid socialization and interpersonal skills. In addition to a psychiatrist, the in-depth evaluation sometimes

includes evaluation by a staff team consisting of a psychologist, a social worker, R.N., and mental health counselors who use psychological testing, individual counseling sessions, family interviews, and social and medical histories to obtain as clear a picture as possible of the person and his or her problems. Treatment efforts routinely include individual psychotherapy and counseling, chemotherapy, group therapy and family therapy, and recreational and occupational therapy. Although the service period is brief, certain basic problems can be dealt with that may enhance the patient's interactions with those around him. As one mental health counselor explains:

> *By the time a patient is accepted for admission here, his physical appearance has often deteriorated right along with his mental state. His grooming has been so neglected that he's physically offensive. His clothes may be practically rags. So we emphasize personal grooming and care, and will provide new clothes. We even have beauticians come in sometimes to help the patients. It's really amazing how a difference in appearance seems to improve the outlook of a patient.*

Each patient is assigned during day shifts to a clinical team, consisting of a casework coordinator, an MSW, two mental health counselors, and a nurse. There are three teams and each one is headed by a casework coordinator. Each team is responsible for recommending a suitable referral for the patient, contacting family members, arranging insurance coverage, and ensuring that the patient's hospitalization does not disrupt employment, welfare payemnts, etc. Team members obtain a complete social history on the patient after a briefing with the intake staff who had initial contact with the psychiatrist who performed the evaluation. Routine medical services and examinations (i.e., blood pressure, temperature, etc.) are provided by medical and nursing staff during the day at specified intervals.

Referral recommendations for patients are presented by the team leader at the daily staffing meeting which consists of clinical staff supervisors. By this time, most of these individuals have had contact with the admitted patients and a decision is made whether to follow the team's recommendation or to explore other possibilities. The team arranges the referral and associated paperwork and information transfer.



Ambulance workers aid police in transporting a patient to MCES.

Specific treatment activities are offered each day and include individual therapy, group therapy, recreation activities, and yoga. Additional activities are designed around a patient's interests by the Volunteer Resources Coordinator and recreational therapist. Any staff member who has significant interactions with a patient is required to note his observations in the record maintained for that patient. Figure 4.2 illustrates a typical daily schedule for MCES patients.

4.2.4 Emergency Transportation

Since August 1974 the emergency ambulance has been available 24 hours per day, seven days per week. This vehicle, which is equipped with basic life-support equipment, can provide on-the-spot evaluation or transportation to MCES or other appropriate agencies. Since MCES is located within 45 minutes of any point in the county, the ambulance can be dispatched quickly to assist police or other individuals. The ambulance workers staffing the vehicle are trained in handling people who are acting violently and are potentially dangerous to themselves and others. Generally, two ambulance workers staff the vehicle when it is used to transport potentially dangerous individuals. During the daytime shift the Ambulance Coordinator is responsible for assignments. The Head Nurses of the other two shifts handle this responsibility.

The immediate value of the ambulance is threefold. First, transportation in a vehicle other than a police car or wagon is calming to the victim since one staff member, trained to handle psychiatric emergencies, is available to speak with the individual during the ride. Second, the police are, by virtue of the vehicle's availability, able to resume their normal duties without taking time to travel to MCES, fill out the requisite petition, and return to their patrol. Since Montgomery County is largely suburban, patrolled by 59 separate and quite small police departments, trips to MCES may remove a large part, if not all, of a given community's patrol force from their patrol duties at any given time. Third, the ambulance is also used to transport patients from the Emergency Service Unit to referral agencies and to bring persons to the Montgomery County Court House. Again, these functions relieve the various county police forces of duties which might interrupt their daily patrol responsibilities.

Figure 4.2
Patients' Daily Schedule

7:00 a.m.	Wake up
7:00 - 7:45 a.m.	Showers for males
8:00 - 8:30 a.m.	Breakfast
8:15 - 8:30 a.m.	Bloodwork
8:30 a.m.	Vital Signs
9:00 a.m.	Medication
9:15 - 10:15 a.m.	Yoga
10:15 - 11:00 a.m.	Ward Meeting (Monday & Thursday)
10:00 - 11:45 a.m.	Patients meet with Doctor or team member
11:00 - 11:45 a.m.	Patients outdoor activity (weather permitting)
11:45 - 1:00 p.m.	Lunch and relaxation
1:00 - 2:00 p.m.	Activity
2:00 p.m.	Medication and Vital Signs
2:30 - 3:30 p.m.	Group Therapy
4:45 - 4:15 p.m.	Patients meet with Doctor or team member
4:45 - 5:30 p.m.	Supper
5:30 - 6:30 p.m.	Medication and Vital Signs
6:30 - 7:45 p.m.	Activities
7:45 - 8:45 p.m.	Group Therapy (Except Saturday)
8:00 - 8:45 p.m.	Ward Meeting (Saturday)
9:00 - 9:45 p.m.	Showers for females
10:00 - 10:30 p.m.	Medication and Vital Signs
11:00 p.m.	Lights out

4.2.5 Crisis Intervention Outreach Team (CIOT)

Referred by a family services program, Mr. J. called MCES requesting that the Crisis Intervention Outreach Team visit his wife. According to Mr. J., she "desperately needs help but refuses to leave the house to see a doctor." A member of the team made an appointment with Mrs. J. which she agreed to with great reluctance. The interview took place several days later in Mrs. J.'s sparsely furnished but immaculately kept home. Mrs. J. was visibly tense throughout the interview, and repeated over and over again that she had no problems except for her husband's ceaseless infidelity. Subsequent interviews conducted by the team's psychologist with Mr. J. and the three teenage children of the family indicated that there were no grounds for Mrs. J.'s accusations. However, the children and Mr. J. were becoming increasingly hostile and impatient with Mrs. J. as she daily repeated her groundless suspicions. Mrs. J. refused to see the psychologist after two home visits. Mr. J. and the teenagers are currently receiving counseling at their local BSU so they can more effectively cope with and understand Mrs. J.'s problems. Subsequent checks by the psychologist have indicated that Mrs. J. may soon be joining the family counseling sessions.

Because of its size limitation (24 beds), MCES has had stringent criteria for admission, even in voluntary cases. However, by mid-1974 it became clear that there was no adequate response for cases involving "near emergencies." As a result, MCES developed a privately-funded Crisis Intervention Outreach Team (CIOT) which functioned from July 1975 to August 1977. (Funding will be available to resume this service in July 1978.) Staffed by a clinical psychologist and a registered psychiatric nurse (both MCES staff), this mobile program supplements existing community resources in delivering psychological evaluation, crisis counseling, and referral services. CIOT staff are available on the 8 a.m. to 4 p.m. shift, during the week, and for a staggered sixteen-hour period over the weekend.

The CIOT visits individuals in the community on a short-term basis. Clients are visited for as many hours as necessary and appropriate referrals are then arranged. Occasionally, in-patient admission to MCES is necessary. The overwhelming majority of CIOT cases have been mental health ones. By providing this kind of immediate, intensive, on-the-spot support, the CIOT program is designed to reduce the number of potential MCES contacts.

4.2.6 Referral

After the emergency is over, many patients continue to require attention for whatever problem gave rise to their initial MCES contact. To the extent necessary, the treatment process will begin at MCES, but the project's primary function is to deal with the emergency by diagnosing the problem and referring the patient to appropriate treatment. As a result of their close ties with the County Mental Health Administrator's Office, and their county-wide jurisdiction, MCES is well suited to serve this clearinghouse function. MCES has referred patients to more than one hundred different agencies. All referrals are specifically arranged with responsible staff of agencies to which patients are being referred, and transportation to the agency is generally provided by MCES. Follow-up phone calls are made by MCES to confirm successful completion of referrals and provide additional information and support needed. Also, the appropriate Base Service Unit and persons originally referring the patient to the MCES are contacted and informed of the nature and importance of the post-emergency treatment referral.

Chapter 5: Criminal Justice Liaison

The largest beneficiary of MCES services, next to the clients themselves, is the criminal justice system, especially the police. This is by design. The project's two articulated goals are: First, to provide Montgomery County with the services detailed in Chapter 4, and second:

> to supplement Montgomery County police services by removing the burden of psychiatric and drug/alcohol emergencies...by providing training to police officers and recruits, and establishing the Criminal Justice Liaison Network, which places human service workers inside selected County Police Departments.

The police are the main criminal justice system component upon which MCES criminal justice liaison activities focus because they are usually the first agency to be called in the case of emergencies. Thus, while MCES has also developed good relationships with the courts, corrections and probation, these agencies tend to be less likely to encounter a psychiatric or drug/alcohol emergency. Prior to MCES the Montgomery County police, however, were faced with a serious burden.

The Problem

Montgomery County is a mix of suburban cities and rural townships. While some of the cities have good-sized police departments, most are quite small. Moreover, the townships typically have four to eight man squads with only one or two vehicles. Thus, in the absence of MCES a psychiatric emergency could seriously affect the police coverage of one of the smaller cities or townships. First

the car, which may represent anywhere from 50-100% of the available police transportation, must be dispatched along with most or all of the community's on-duty law enforcement manpower. Then, once on the scene, such emergencies are not often speedily resolved. Although the individual experiencing the crisis may not have committed an offense, he or she is usually difficult to subdue. If the situation cannot be stabilized at the scene, the more difficult question arises--"What should be done with this individual?" Before MCES came into being, few agencies or institutions were equipped to handle such emergencies and fewer still were willing to accept such patients on a moment's notice. The end result was usually an arrest (often, simply to justify custody) and a night or two in a detainment cell or drunk tank. As one police chief said, *"Those of us who go back a few years in our police experience well recall the problems prior to the inauguration of MCES. It was next to impossible to get even telephone contact with a professional. When we would have to actually pick up someone, it would practically take an act of Congress to have a facility take the person off our hands to start to aid the patient with his mental problem."* As a result, the individual received little attention at a critical time and the police invested considerable time in what was an enforcement problem by default only.

The MCES Response

As the project's goal statement indicates, MCES intended to relieve the police of this burden and it does so in three ways. First, the Building 16 facility accepts patients who are experiencing a psychiatric or drug/alcohol emergency on a 24-hour basis. Second, MCES offers in-service training to police in crisis intervention for the purpose of curtailing crises on the spot, without resorting to additional means. In addition, MCES has developed a criminal justice liaison network which places human service workers inside selected police departments who are available to assist the police in such crises. Third, if and when it becomes apparent that additional treatment will be necessary, the MCES emergency ambulance is available to provide the transportation and thereby engage the client in immediate treatment while alleviating a potential drain of police manpower. Chapter 4 has already discussed the service components of the MCES facility and the ambulance operations. The remainder of this chapter will discuss the criminal justice liaison activities.

5.1 The Criminal Justice Liaison Coordinator

MCES designated the job position Criminal Justice Liaison Coordinator to handle the job of developing police contacts, explaining MCES to the police and conducting police training. The first task undertaken by the coordinator was to introduce himself to the 59 county police chiefs, which he did by letter. That letter frankly noted the problems which police have had with mental health programs in the past and that MCES intended to be an exception to that experience. It went on to explain that both the police and MCES could only benefit from the relationship if channels of communication remained open and if each were candid with the other about any problems either agency was having with the other. The letter was preceded by a general announcement at the Montgomery County Chiefs of Police meeting by that organization's president who also happened to be a member of the MCES Board of Directors. The letter was followed by a personal visit to each chief and arrangements were made to have the coordinator meet the line staff and explain MCES to the officers. Those meetings were the kickoff of the police/MCES relationship. The coordinator simply explained the role of the program with regard to the police, based on the following list of what the police would and could not expect from MCES:

What police can expect from MCES:

Willingness to:

1. Advise on all cases.
2. Evaluate appropriate persons who seem to be in an emergency state.
3. Admit via appropriate 201 (voluntary) and appropriate 302 (involuntary) commitments.
4. Follow up on any case you had trouble with.
5. Send out ambulance when available.
6. Have CIOT look into cases that are not emergencies but may become an emergency.
7. Discuss with you your training needs, counseling resources, relationship between you and other agencies, etc.

8. Refer you to other resources when your case is not appropriate.
9. Understand your NEED to save time.
10. Confer with you about legal matters of a patient you referred within the limits of law (confidentiality).

What police can't expect from MCES:

1. To stretch the Mental Health Procedures Act of 1976.
2. To breach confidentiality.
3. To go beyond our limitation of 24 beds which has to service all of Montgomery County.
4. To become police agents.
5. To have every case work out smoothly from contact through admission and discharge.
6. To not have our own internal problems which can at times affect our delivery of service (persons out sick, etc.).
7. To admit everyone that seems appropriate to you.
8. Perfection.

Even after the channels of communication were open and the police were putting MCES to use, the coordinator's role required that he continue to pay periodic visits to each department for training and liaison activities (discussed below). In addition, the coordinator took on the added responsibility of trouble-shooter. Each case that involves police contact is now followed up by the coordinator, who speaks directly with the officers involved. If there are any problems, they are addressed either by correcting a MCES procedure that could be improved upon, or explaining the statutory, medical or other reason for which events transpired the way they did. In addition, the trouble-shooting role also involves case disposition. In cases where criminal charges are brought, the coordinator also acts as liaison to the prosecutor's office. When applicable, this results in charges being dropped or continued. When this occurs it is often the result of an agreement, worked out by all parties, to place the patient in a treatment program that meets his or her needs. To this end, the coordinator has developed and maintained contacts with other treatment facilities in the County. Of course, there may be occasions where the charges should

not be dropped. In those instances, it is the coordinator's role to insure that the treatment process will continue for as long as possible prior to adjudication and to whatever extent possible afterwards.

The success that has been achieved by the MCES Criminal Justice Liaison Coordinator is evidenced by the number of criminal justice contacts at MCES. From February 1, 1974 to May 30, 1977, 3,453 (30%) of the 11,374 total MCES contacts were police referrals. Furthermore, 41% (1,206 out of 2,968) of all admissions were from these referrals. An additional demonstration of police support occurred during the last grant cycle when the various police departments were asked if they would send letters of endorsement. Many of the departments responded, each with praise for MCES. The following letter from a police chief is presented because it represents the spirit in which they all were written, and also offers insight into the actual workings of MCES.

To the Administrative Director of Montgomery County Emergency Service:

During the past year, we have become increasingly aware of services provided by the Montgomery County Emergency Service. This has come about through the efforts of the Criminal Justice Liaison of Montgomery County Emergency Service. Problems of understanding that existed have been greatly reduced, enabling our Department to more effectively use the Service. As a Department, we are now more familiar with the criteria necessary for referral and are thus better able to secure the necessary information. We are also anticipating an in-service training program to be held jointly among Hatboro, Lower Moreland, and our Department, for the purpose of teaching the police officers how to better deal with emotionally disturbed persons. The Criminal Justice Liaison Coordinator has agreed to present this training.

The open lines of communication maintained by the Montgomery County Emergency Service proved to be a great asset to us in September of last year when a mentally disturbed man came to our headquarters, alleging to have murdered a person in Port Jarvis, New York. The man agreed to a voluntary commitment while our Department continued an intensive investigation. While the claim proved to be false, cooperation between the Montgomery County Emergency Service and our Department proved most beneficial to the patient and to our investigation.

December of 1975 saw our first use of the Emergency Service van. An adult female was exhibiting severe emotional disorders and had been institutionalized in the past. Her actions and violent behavior necessitated commitment. Transportation by our police officers would have resulted in the removal of two officers from Patrol duty and would have required heavy restraints on the subject. Despite restraints, the patient could have inflicted injury to herself and damage to the vehicle. Transportation was provided by the Emergency Service van with trained attendants. This made the situation much safer for the patient and much easier for us.

We look forward to an increasing understanding of the emergency services provided, more knowledge of the proper handling procedures for emotionally disturbed persons, and continued communications with the Montgomery County Emergency Mental Health Service.

Chief of Police
Town of Upper Moreland

5.2 Police Training

MCES is involved in training the police of Montgomery County in two ways. First, the Criminal Justice Liaison Coordinator participates in the formal training program for police recruits at Montgomery County Community College. The program consists of 420 class hours of which 80 are directed to "Human Services." The Criminal Justice Liaison Coordinator is responsible for assisting in the crisis intervention instruction. In addition, the class includes a tour of the MCES facility and a discussion of the ways it can aid the police officer. The instructor for the entire course in Human Services at the police academy is a former MCES Criminal Justice Coordinator. Second, in-service training is provided to line officers. Generally, this training is delivered by the Criminal Justice Liaison Coordinator who schedules sessions at the various police stations, and, on occasion, at the MCES facility. In 1976 many of the Montgomery County police departments received MCES crisis intervention training seminars in addition to the course taught to the recruits on how to use MCES. The following is a synopsis of the MCES utilization training guidelines for police that might be of use to replicators:

- *The Decision to Contact MCES. First, call the MCES intake office using the hotline number to get a*

preliminary determination of whether the case would be appropriately and adequately serviced at the facility. Be prepared to describe the characteristics of the patient and situation as fully as possible, so the telephone worker can determine and advise where the patient should be brought. It is important to remember, however, that being advised that a patient should be brought to Building 16 for evaluation does not guarantee admittance. The ultimate authority of deciding suitability for admission under any circumstances rests with the examining physician.

- *Suitable Referrals include: people who appear to be under the prolonged influence of drug and/or alcohol or are suffering from a mental disorder, and who, in your opinion, would benefit more from a detoxification/ rehabilitation program and/or psychiatric care and treatment than immediate penal incarceration; persons exhibiting urgent psychiatric problems such as suicidal behavior, depression, agitated, confused, aggressive or fearful mental states, and other situations where there appears to be immediate risk to the individual and the people around him; as well as persons exhibiting such drug or alcohol problems as acute intoxications, withdrawal states, addictive problems with serious social or psychiatric complications.*

- *Conditions for Admission. MCES will try to admit any person who requires help. However, there are a few restrictions and conditions that may result in someone being turned down for admission to the in-patient unit. Be aware of the following:*

  - *The unit is primarily set up for an adult population. (Like most states, the Pennsylvania Commitment law has a minimum age requirement of 14.) Thus, the Police are advised to initially follow their department's standard procedure for handling juveniles. Later, juvenile authorities can contact MCES if they deem it necessary.*
  - *Life-threatening medical problems cannot be treated at MCES. Serious medical or surgical problems should first be taken to the nearest general hospital emergency room. Following examination and treatment in the emergency room, the patient may then be accepted for evaluation by Building 16. It is best that the*

MCES staff conduct a training session in crisis intervention for a local police department.

emergency room physician make the referral to MCES so that a thorough report of the patient's medical condition can be made to the psychiatrist on duty.

- *Chronically bed-ridden patients and those who are not physically able to provide basic self-care such as eating, washing, and toilet care are not suitable for admission.*

- *Patients who are charged with a crime. Whenever a person is committed or admitted to MCES and has criminal charges pending aginst him, it is advised that the police officer or district justice inform the Building 16 staff of the patient's obligations with respect to the criminal justice system, including:*

  - *Date and time of hearing.*
  - *Notice in advance of police or sheriff's department transportation arrangements to hearing or elsewhere.*
  - *Expectations of criminal justice system from our staff. Do we merely perform an evaluation and make recommendations in preparation for a return to the criminal justice system, or shall we proceed with noncriminal placement?*
  - *Notification of changes in status of patient, i.e., have charges been dropped, added, or will they be pursued?*

  Also, evaluations may be performed at Building 16 before a person is transported to the Montgomery County Prison. If the district justice determines that an evaluation would benefit the prison staff and the court, he may order the police to route the patient through the Emergency Service Unit. Such evaluations may be helpful by alerting the prison staff to potential problems and by providing diagnostic material if an incompetency hearing and/or commitment is later pursued.

Since the passage of the new Mental Health Procedures Act, the Criminal Justice Liaison Coordinator, with the support of the County Chief's Association, has also been instructing the police on the meaning of the Act's various provisions and required procedures. To facilitate proper usage, the coordinator has also prepared wallet-sized cards that officers can carry with them and keep in the visor of the cruiser which synopsize the Act's salient features.

5.3 Liaison Network

The Liaison Network was established in the summer of 1976. Since that time six police departments have participated. The program is coordinated by the Criminal Justice Liaison Coordinator who oversees the placement of volunteer staff in the police departments for a minimum of 15 hours per week to handle cases which present psychiatric and/or drug and alcohol problems. The volunteers are all students working in the program for course credit. No evaluation of the program has been performed as yet because of the newness of the efforts. However, the Criminal Justice Liaison Coordinator who oversees the liaison network stays in close contact with the participating departments. Their feedback has been overwhelmingly positive. If one considers the usual resistance on the part of law enforcement personnel to civilians participating in police work, the reaction to date indicates unusual police confidence in MCES services. Several additional police departments have requested to participate in the liaison network program.

All the students who are participating in the program are majors in the social services field who have had crisis intervention training. Individual assignments to police departments are, of course, subject to the Chief's approval. Formal orientation and training classes are conducted at MCES. The students became familiar with the functions of the Emergency Service as a result of an orientation that consists of oral presentations of various aspects of the program, discussions with the telephone coordinator and intake staff, meetings with team leaders and counselors, and participation in most functions of MCES.

Perhaps the best example of how the Liaison Network operates is offered in the following memo which a Liaison Network student left for the Chief of the Franconia Township Police Department (a four-man department):

> *Chief--*
>
> *If Danny A. (a teenage boy who had recently attempted suicide) or his mother calls, tell them I'll be in by this evening. I'll be out this afternoon:*
>
> *1. Going to try to speak with the alcoholic that Debbie C. (social worker) told us about.*

2. *Going to Sellersville with Social Security papers to explain the procedure to the Portuguese translator so we can work with the family from the Senior Adult Action Center.*
3. *Going to talk to my professor about being able to stay longer.*

5.4 Conclusion

It is evident that the MCES has developed an extraordinary relationship with the various police departments of Montgomery County as well as relieving them of the burden of handling psychiatric, drug or alcohol emergencies. This relationship has fostered a mutual understanding of the problems inherent in effective police work and emergency psychiatric, drug or alcohol care. The product resulting from this cooperative effort between the police and MCES is greater than the sum of its individual parts.

Chapter 6: Costs and Third Party Billing

The cost of maintaining a fully accredited hospital as well as supplementary services such as the hotline, ambulance, CIOT, and criminal justice liaison program that MCES provides is significant. In FY 1977 the total program budget was $1,256,505. No doubt, such a yearly budget would be prohibitively expensive if maintained exclusively by grant funds and would, in all likelihood, be short-lived. After one year of grant funding this became apparent to MCES administrators and the Board of Directors. As a result it was decided to pursue the possibility of third party reimbursement (i.e., reimbursement by private medical insurance, Blue Cross and public assistance health programs). Now, only three and one-half years after beginning third party billing operations, 97 percent of all billings are supported by third party payers. This section of the manual will detail the transition from program funding to fee for services, the advantages of third party funding, the obstacles that replicators can expect to encounter along the way, and the ways MCES successfully overcame those obstacles.

6.1 The Transition to Third Party Reimbursement

At the outset, the Board of Directors had no long-range goals beyond fulfilling the Pennsylvania mandate to provide 24-hour drug, alcohol, mental health and mental retardation services. This itself was an innovation in that Montgomery County was the first to centralize those services in a single facility, and to conceive of the supplementary services, as noted in Chapter 2. MCES was, at that time, entirely program funded. The bulk of the funds, $520,000, were provided by the County mental health/mental retardation and drug and alcohol program funds. In addition, the Governor's Justice Commission (the State Criminal Justice Planning Agency) provided $152,136 from LEAA monies earmarked for police

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coordination and cooperation. This was used specifically to support the criminal justice liaison program and the emergency ambulance. Finally, a $130,000 contract with Eagleville Hospital as part of a grant from NIDA was secured to supplement the drug and alcohol detoxification program. The yearly budgets for MCES are as follows:

1/74 - 12/74	$ 630,000
1/75 - 12/75	852,892
1/76 - 12/76	920,433
1/77 - 12/77	1,256,505

$712,684 of the $1,256,505 shown for 1977 was provided by third party payers.

Much of the first year funds were used for salaries, building renovations and equipment. Although MCES has no rental overhead, having leased a building from the Norristown State Hospital, on hospital grounds, for the nominal fee of one dollar per year, the cost of renovation over a three-year period has approached $350,000. The potential availability of similar arrangements and viable alternatives elsewhere are discussed in Chapter 7, Replication Issues.

After one year of program funding, it became increasingly obvious to administrators and the Board of Directors that the growing number of patients resulting from the burgeoning awareness of MCES' existence by the social service and law enforcement communities, coupled with the ever-increasing cost of health care, was sure to result in significantly greater budgets in the coming years. Moreover, the County Mental Health Administrator's Office could not guarantee long-term financial support of greater proportions than those allocated, and grant monies, if continued at all, would be in progressively diminishing amounts. In short, MCES was a project that met a clear need, was accepted and used by its intended clients in growing numbers, but might be forced to restrict operations, and limit patients simply because of increasing expenses.

Experienced in hospital administration, the program administrators and members of the Board of Directors considered the alternatives. The only viable solution, they felt, was third party reimbursement (TPR) -a shift from program funding to fee for services. In analyzing the problem, MCES directors recognized the following

advantages to third party funding.*

- TPR can affect the uncertainties of grant program funding. Specifically, neither the County, Eagleville Hospital (through NIDA) nor LEAA could guarantee the same level of funding in the future. Generally, all programs are competing with others either in existence or on the planning board. Furthermore, with a budget as large as MCES' the usual process of institutionalization by a county or state agency is considerably more difficult. As noted earlier, it was difficult to imagine or expect the county to provide more funds than they already were providing.

- TPR offers greater flexibility in money allocation. Grant and program funds are typically earmarked for a specific purpose such as staff salaries or a particular treatment modality. There are clear limitations on how these funds can be spent. However, the actual treatment process does not always conform to these rigid allocations. At various times equipment might be more necessary than additional staff, and clients may be of a different nature than expected. Thus, while grant and program funds can continue to support specified needs, their optimal use is to complement the non-earmarked TPR funds.

- TPR imposes an administrative and recordkeeping system that complements the entire treatment process. The elements of an administrative system needed to support the third party process are also elements of an effective quality and management control system. The process of accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH), knowledge of unit costs, a fee schedule that reflects unit costs scaled by ability to pay, client-specific records of services, treatment plans, and clinical progress notes are useful tools for administering a program, for improving the efficiency of the program, and for controlling the quality of services rendered.

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* For further analysis of third party billing see "A Manual on Third Party Reimbursement Strategy for States and Communities," DHEW Publication No. (ADM) 77-499.

- TPR is designed to handle the effects of inflation and the dramatic increases in the cost of health care. The fee for services is based on the actual cost of treatment. Inflation is factored into that cost. Thus, unlike grant funding, TPR-funded projects can continue to treat the same and even greater numbers of participants.

MCES administrators were also aware of potential problems affiliated with TPR. The two most notable concerns were:

- TPR can create cash-flow problems. Reimbursement may take anywhere from three to ten weeks (and on occasion, even longer). As a result, a program must have some cash reserve when effecting the switch. Also, cash flow, in a TPR program, is directly related to program utilization. Therefore, a project must also maintain a cash reserve to meet occasional spells of under utilization.

- TPR could induce discrimination in favor of persons with coverage. Once a program becomes reliant on TPR for financial viability, ability to pay (or demonstrate coverage) may become an admission priority. This, of course, is contrary to the MCES stated philosophy of never refusing admission to any patients on the basis of financial resources.

The cash flow problem was met by easing into a TPR system, while grant and program funds served as an ongoing supplement. The lesson for replicators is that TPR should be a gradual process, coming only after the program has been well established in terms of cash reserve and client uses. The problem of favoring those with coverage has been met by institutionalizing the philosophy that all patients in need of treatment will be admitted regardless of their ability to pay or whether they possess insurance coverage.

6.2 Accreditation

The first step in the transition to third party billing was accreditation. MCES was not, at its inception, an accredited hospital. Thus, while it met all the county requirements for a 24-hour emergency MH/MR/D&A facility, it had not yet been inspected

Patients and their families attend a counseling session conducted by a psychologist.

by state and national accreditation organizations and thus few, if any, third party payers would make reimbursements.

MCES underwent a three-step accreditation process. The State of Pennsylvania, Department of Public Welfare (DPW) has established numerous state regulations for all hospitals. Unless those regulations are met the state will not reimburse a facility for treatment through either Medical Assistance or Medicare. MCES had little problem meeting logistical, facility and equipment regulations since location and renovation were accomplished with this in mind. However, DPW approval, while necessary for Medical Assistance and Medicare billing, does not guarantee either private insurance carriers or Blue Cross reimbursement. Approval by the latter is critical for the success of a TPR system for three reasons. First, many private insurers will follow once Blue Cross has approved. Second, Blue Cross can act as a fiscal intermediary for Medical Assistance and Medicare payments. This is a crucial role because neither Medical Assistance nor Medicare will make reimbursements to hospitals without approval of the bill by a designated fiscal intermediary. The fiscal intermediary's approval certifies that the patient was diagnosed as having a particular treatment need, that the treatment facility is capable of fulfilling that need, and that treatment was indeed provided in a manner consistent with accepted medical practice (see the discussion of Utilization Review below). The intermediary is typically a large supplier of third party funds, such as Blue Cross, which has the requisite staff and expertise to perform this task. Third, and perhaps most importantly, Medical Assistance programs are often willing to abide by the rate of reimbursement established by Blue Cross. Therefore, MCES set out to gain Blue Cross approval.

The second step in the process was accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH). The JCAH, a nonprofit, nongovernmental organization, is sponsored by four major hospital and medical groups: the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association. It is the only interprofessional standard-setting and evaluating organization of its kind. While no state and federal law requires JCAH accreditation, its certificates are often required as a condition of funding or third party reimbursement. Because JCAH accreditation is such a major factor in gaining TPR and in providing hospitals with a method of evaluating their performance and goals, it is expected that replicators will also seek JCAH accreditation. Therefore,

the following brief synopsis of the process is presented here, not only as an indication of the vigorous evaluation that MCES has experienced, but also to aid replicators in their own TPR efforts.

The JCAH standards relate to several aspects of a hospital's operations including: an organized medical staff; governing bylaws; fire safety and construction codes; patient services such as nursing, dietetics, pharmaceutics, pathology, medical records, radiology and others; and standards requiring that the hospital's medical, nursing and other professional staffs implement methods to evaluate themselves and the quality of their services on an ongoing basis. Building 16, in which MCES is located on the grounds of Norristown State Hospital, does not have the capacity to provide many of the services required by the JCAH, including dietetics, radiology, and complete medical support. This presented an obvious problem to the administrators and appeared to be a possible bar to JCAH accreditation. One alternative was to move the facility, if appropriate space could be found in an existing accredited hospital. This idea was rejected because the administrators and Board of Directors believed it would create more problems than it solved. Specifically, MCES could lose its autonomy and individual reputation which was growing rapidly, especially within the law enforcement community. In addition, the administrators could foresee problems in areas of admissions policy, billing procedures, and staff responsibility and authority.

It was decided that, rather than bringing MCES to a facility with the required services, those services could be brought to MCES. A contractual arrangement was made with Norristown State Hospital to provide dietary services, and MCES entered into a reciprocal arrangement whereby it would provide Montgomery Hospital with backup psychiatric services in exchange for medical support. For the rest, MCES was prepared to face the JCAH accreditation team on its own merits.

The JCAH accreditation process involves two phases. After applying for accreditation, the hospital is required to complete a comprehensive questionnaire related specifically to JCAH standards. The completed questionnaire is returned to JCAH where it is analyzed and used to pinpoint areas that may require special attention during the on-site survey. The hospital is notified four to six weeks in advance of the survey team's visit. It

must, in turn, post public notice of the upcoming survey to inform the general public of the opportunity to request a "public information interview." A public information interview, if requested, is usually held on the first day of the survey visit. The interview allows any interested party to present information related to the hospital's compliance with the standards of the JCAH. The information received in such an interview is considered during the survey and in the accreditation decision process.

The JCAH survey team generally spends two to three days evaluating those aspects of a hospital's operation that are covered by the standards. At the conclusion of the on-site survey, the team conducts a summation conference to discuss its findings with appropriate hospital personnel, including members of the governing body and medical staff. Following the summation conference, the surveyors complete their report and submit it to the JCAH central office for review. In this report, they make their recommendation for the accreditation status of the hospital based on their survey of the facility.

At JCAH headquarters, the survey report is reviewed and analyzed by a trained professional staff of physicians, registered nurses, and hospital administrators. This staff, too, makes an accreditation recommendation based on its review of the survey report.

The surveyors' report, the hospital's completed questionnaire, information received during the public information interview, and other documentation that may be required are then presented to the Accreditation Committee of the JCAH Board of Commissioners for its accreditation decision. This decision, which is always accompanied by comments and recommendations, is then sent to the hospital. Within a few months of filing their application, MCES received accreditation from the JCAH.

The third and final step in the accreditation process was the investigation of MCES by the Health Services Council, also an independent organization that contracts with Blue Cross. Their survey also includes a site visit and is included with a proposal to their Board which indicates, among other items, the facility's treatment capacity, philosophy, and need within the community. This report is in turn presented to Blue Cross and a decision to

contract with the hospital and act as fiscal intermediary is then made. If Blue Cross does decide to contract with a particular hospital, it may choose to do so in one of two ways, either by a "special" contract or a "cost" contract. The former is a designated rate which considers the cost of services but also considers such factors as the nature of the service, the availability and cost of these services elsewhere, and the need. A cost contract, on the other hand, simply reimburses the hospital at a rate, determined by the hospital's accountants, which reflects the actual cost to the hospital to provide the services based on the hospital's budget.

Prior to negotiating a contract with Blue Cross, the MCES Board of Directors and administrators decided to retain an accounting firm with experience in the medical field to assist them in effecting the transfer to fee for services. Choosing a qualified accounting firm has turned out to be one of the most critical decisions in the project's history. The new accountants who almost exclusively handled hospitals or medical associations, helped to institute the billing procedure which was intact by the time negotiations began with Blue Cross, and they were instrumental in negotiating the ultimate rate at which Blue Cross would reimburse. Initially, Blue Cross was unable to visualize the exact nature of the program and was therefore reticent to contract with MCES. The accountants, however, were able to demonstrate the similarity of MCES' operations with an Intensive Care Unit of a hospital. Furthermore, the accountants pointed out that, because of the similarity of diagnosis, treatment, and stay for all MCES patients, a single all-inclusive rate could be established as opposed to asking Blue Cross to attempt to break down component services. The end result was that MCES entered into a special contract with Blue Cross at $85.00 per day (which was then also accepted by Medical Assistance) and Blue Cross became the fiscal intermediary for the state. The $85.00 per day rate was determined by dividing the yearly capacity (24 beds x 365 days) into the money that had been allocated over the previous year for medical care, plus a small inflation factor. This is different from a cost contract which does not assume full capacity but rather arrives at a rate by dividing actual use by actual cost. In early 1976, when the Blue Cross special rate of $85.00 per day was contracted, the accountants employed the cost formula to establish the rate for private insurers of $120 per day. Of course, as costs rise these contracts are subject to renegotiation. The current rate of reimbursement is $146 per day for Blue Cross and Medical Assistance and $200 per day for private insurers.

Of course, individual overhead factors and the level of immediacy necessary in establishing a third party liaison will affect these rates on an individual basis. The MCES rates should not be considered a yardstick for replicators.

6.3 Billing

The design of the MCES billing procedures is based on requirements of Pennsylvania law coupled with the best medical billing practices known to the MCES accountants. The billing procedure begins when the admitting doctor fills out an admission review form, which Pennsylvania law requires and which indicates the attending physician's plan of treatment, including diagnosis, indication of need for admission, orders for medications, treatment, group therapy, recreational therapy, occupational therapy, psychiatric and psychological evaluations and diets and plans for continuing care upon discharge, as appropriate. The admission review form is then forwarded to the Utilization Review Coordinator. Each hospital, in order to receive Medical Assistance reimbursement, must have a Utilization Review (UR) Coordinator whose job it is to represent the patient and the third party payer. The UR Coordinator receives from the admissions office the admission review form, along with:

- patient's medical record number;
- physician code number;
- date of admission;
- responsible third party payer, if any;
- diagnosis(es) or problem(s); and
- physician plan of care.

The Utilization Review Coordinator, or the Coordinator's assistants screen each admission to determine the medical necessity and appropriateness of admission. The medical record is reviewed and findings are compared with the level of care criteria and standards for the admitting diagnosis. These criteria standards are prepared by the hospital medical staff pursuant to the Department of Public Welfare regulations cited earlier and comprise the Hospital's Utilization Procedures Manual. Based on these standards the UR Coordinator will determine the appropriateness of the admission

The Head Nurse reviews new admissions with another nurse.

and assign an initial length of stay indicated by the Manual. That report is then forwarded to the billing department and is the maximum extent to which MCES may bill unless an extension in treatment needs is filed in writing to the UR office by the treating physician. It is the utilization review report that confirms that each admission is warranted.

The billing department, when treatment is completed, informs the third party payer and requests eligibility forms. These forms are then attached to the bill and forwarded to Blue Cross (or private insurance when applicable) which approves and, when acting as intermediary, forwards the necessary forms to the Department of Public Welfare in Harrisburg which then forwards payment to the MCES. The entire process takes anywhere from 3-10 weeks, when everything goes smoothly.

Unfortunately, as hospital administrators know, everything does not always go smoothly. Unlike many hospitals, MCES admits all patients in need of treatment and asks questions about ability to pay later. This basic philosophy of the program is a major source of its community support and was a large factor in the decision to remain autonomous. It does, however, create a major problem for the billing department--who is going to pay?

A TPR-supported program cannot last long if it cannot answer this question. Of course, every effort is made at intake to determine what insurance coverage exists, if any, and if none whether the patient has a Medical Assistance card. If he or she has either, there is no problem. However, because of the nature of MCES clientele such determinations are not typically easy. Even if coverage exists the patient may not know or may not be able to communicate the information. As a result, the billing department staff have taken on the unique role of "insurance investigators," assuming the task of locating the medical coverage if it does exist, or if it does not, facilitating the application and granting of a Medical Assistance card. Their task is particularly difficult insofar as they often have only 72 hours to perform the task. However, this effort is important not only to ensure reimbursement and continued MCES existence, but also to ensure that extended treatment will be provided if MCES must refer the client for continued treatment at another facility whose admission policy is not as liberal as that of MCES.

At first, locating medical coverage information for referrals was not easily accomplished. Medical Assistance applications are detailed and require information not always available. As a result they would often be returned from the local MA office stamped "incomplete." In hopes of remedying the situation, the head of the MCES billing department invited the County Medical Assistance Supervisor to visit Building 16. After having the operations explained, the County Supervisor was taken on a tour of the ward. In the recreation room, he happened upon the not unfamiliar sight of a billing department clerk with a pencil in her teeth and an MA application on her clipboard, crawling on all fours next to a patient (who was doing the same) in an attempt to complete the application. From that point forward, the County MA office not only processed "incomplete" applications from MCES, but also appointed a staff worker as MCES liaison to work with the billing department in expediting applications.

6.4 The Success of TPR

As shown earlier in this chapter, the yearly MCES budget is currently in excess of $1.25 million, which necessitated the need to seek third party financial support. The billing and statistical overview set forth in Table 6.1 indicates the progress made. In 1976, third party payers provided an average of 70% of the program budget, excluding LEAA and NIDA grants which support the Liaison Program, the ambulance, and the CIOT staff. In 1977, an average of 93 percent of billings was provided by third party payers, and of the remaining 7 percent paid by the county, 2.5 percent supported involuntary (Section 302) admissions for which the county is required to pay under the new law. Thus, after only three years of operations, the total yearly non-reimbursable cost of all MCES facilities and services is approximately $250,000 (grant funds plus 4.5 percent of third party billings).

In sum, it appears that MCES has made a successful transition to TPR. However, it cannot be overstated that the key work is transition. The problems of cash-flow, acceptable rates and client use could almost surely doom any attempts to begin such a project with a TPR base. In the case of MCES, the transition took approximately two years and required a total of $1,773,915 before reimbursement monies were received. It would appear that, next to the clients, the real benefactor of the program is the law enforcement community, and thus the public. Over the first three years, the law enforcement funds contributed to MCES totalled only $336,547. Chapter 8, Results and Evaluation, will examine just what that money bought.

CONTINUED

1 OF 2

Table 6.1
1977 BILLING STATISTICAL OVERVIEW

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Average
Patient Days Per Month	516	486	547	472	557	501	487	505	570	510	589	535	523
Medicare Percentages	12%	6%	7%	4%	8%	8%	7%	7%	12%	10%	10%	12%	8%
Blue Cross Percentages	8%	10%	19%	8%	10%	10%	12%	5%	8%	8%	8%	8%	10%
Medical Assistance Percentages	62%	73%	58%	75%	67%	70%	63%	73%	61%	64%	51%	60%	65%
Private Insurance Percentages	12%	6%	7%	5%	12%	9%	15%	8%	11%	12%	16%	7%	10%
Bucks County											4%	1%	
Total % Billed to Third Party Payers	94%	95%	91%	92%	97%	97%	97%	93%	92%	94%	89%	87%	93%
Total % Billed to County	6%	5%	9%	8%	3%	3%	3%	7%	8%	6%	11%	13%	7%
Involuntary Adm.	2%	2%	2%	6%	2%	2%	1%	6%	1%	3%	4%	4%	3%
Voluntary Adm.	4%	3%	7%	2%	1%	1%	2%	1%	7%	3%	7%	9%	4%

Chapter 7: Replication Issues

The availability of psychiatric emergency and detoxification services has escalated dramatically in the past ten years. The provision of these services reflects not only significantly increased population needs but also changing attitudes towards methods of handling such problems. Traditionally, intervention at the height of a crisis was rarely available and access to services was predominantly for those who could pay. City hospitals, police departments, and in some instances state hospitals provided the only alternatives for emergency situations.

The Federal Community Mental Health Centers (CMHC) Act of 1963 initiated the development of mental health emergency services accessible to all regardless of ability to pay. While treatment services to individuals with alcohol and drug-related problems were not required under Federal legislation until 1975, state and local authorities had taken steps to provide detoxification facilities in many urban and suburban areas.

Concurrently, legislatures recognized that police should not be expected to handle some types of behavior and the act of public drunkenness was decriminalized or police were encouraged to use detoxification centers as an alternative to arrest. The rapid growth in substance abuses necessitated detoxification centers to provide medical care and prepare individuals for rehabilitation services. Finally, the movement towards deinstitutionalization prompted the development of comprehensive psychiatric care in local communities to allow individuals to remain in their community. Clearly, emergency intervention services are an integral component of any effort to strengthen these community treatment options.

The importance of immediate crisis intervention goes beyond reducing the harm to the individual; it extends to the environment in which the crisis occurs by reducing the potential for injury to others in the community. The Montgomery County Emergency Service clearly fulfills a common need--emergency intervention, treatment, and referral for aftercare. While around-the-clock emergency and detoxification care exists in some form or other in most moderately to extensively populated areas, the combination of all MCES' service components, psychiatric services and detoxification for addicts and alcoholics in a free-standing facility is highly unusual. This chapter examines the external factors that have contributed to MCES' success and the internal design of services.

7.1 Environmental Factors

The impetus for the development of the Montgomery County Emergency Service was originally a desire by the County Mental Health Administrator's Office to fulfill the state requirement for 24-hour emergency service coverage. This particular mandate, modeled on the Federal Act of 1963, exists in some form or another in all states' legislation or regulations pertaining to Community Mental Health Center services and funding eligibility. As detailed in Chapter 2, the concept of a psychiatric emergency service gradually evolved in Montgomery County to include detoxification for drug addicts and alcoholics. Since drug and alcohol agencies are under the jurisdiction of the County Mental Health/Mental Retardation Administrator's Office in Pennsylvania, funding and administrative requirements were relatively simplified. Nevertheless, MCES obtained its present form because of key inter-agency, community and governmental support for a dual-purpose emergency service. The County Commissioners strongly supported the idea and funded all renovation costs.

Most metropolitan areas of any size now have some provision for emergency psychiatric and detoxification services. Again, these services do not typically exist in one unique facility. Generally, these services are administered as part of larger hospital complexes or are separately provided from free-standing facilities. However, provision of psychiatric emergency care and drug and alcohol treatment, as noted earlier, are now Federal mandates for Community Mental Health Centers, and thus, in the future, detoxification and psychiatric emergency care may be more frequently

The Intake Coordinator questions a distraught woman brought to MCES for help by police officers.

administered jointly. Impediments to operating the two together have centered around concerns for treatment specialization (e.g., drug detoxification treatment approaches are distinctly different from psychiatric treatment) and problems of administrative, political, and financial jurisdictions. Finally, one type of emergency is often perceived as of paramount importance in a community and resources may be mobilized to meet that need while other types of crisis situations remain relatively neglected.

There are several advantages to combining and delivering comprehensive emergency care and detoxification in one location. First, police, community agencies, and individuals know that they may turn to one organization that is prepared to handle any type of crisis situation. Secondly, according to the Medical/Executive Director of MCES, the broad focus of such a facility allows it to diagnose and treat emergency patients in a comprehensive manner since the program is not geared toward a specific problem and treatment. For example, a client referred to MCES for an addiction crisis also might have a psychiatric problem. The range of staff and the linkages that MCES has with all kinds of service agencies enable it to diagnose, treat, and arrange subsequent care for such an ancillary problem that might have an adverse effect on the addiction problem.

While these advantages benefit the community and patient alike, it should be noted that the centralization of services for differing emergencies can be fulfilled by other means. For example, a hotline with intake workers can evaluate and notify the respective facility that a psychiatric case or detoxification case will soon be arriving. Such a service could also have a van to relieve police or others of the transportation need. This service could easily be implemented (and does exist) in communities where detoxification and psychiatric emergency services are available at various hospitals or facilities. While MCES may represent a fairly unique approach to common problems, it should be emphasized that any one element of its services can be easily replicated and joined to an existing service.

7.2 Service Components

MCES has combined a comprehensive assortment of services to ensure that emergencies or near emergencies are efficiently handled. For example, a telephone call from an individual in need of immediate aid can result in the dispatch of the emergency ambulance to transport him to MCES or a visit from the Crisis Intervention Outreach Team. If transported to MCES, the individual can be evaluated on the spot and admitted if necessary. Treatment can begin in a matter of hours after the initial phone call.

The replicability of each of the services provided by MCES is briefly examined below.

Emergency Telephone (Hotline)

Most communities have some form of emergency telephone service. In some, they are service-specific (rape, drug, or psychiatric hotlines) or "rap" lines where limited counseling is provided over the telephone. Others have general emergency service numbers and still others rely on 911. However, many of these, whether they are service-specific or not, are not directly connected with both a transportation service and an in-patient treatment unit. Often, they must call other agencies to obtain one or both of these services. The MCES emergency phone service, unlike others, puts the user in direct and immediate contact with professional staff at the facility where emergency treatment will ultimately be provided, if necessary. Once a program like MCES has become operational there should be no bars to replicating the emergency telephone service. This service may be a component of the whole or simply serve as a central intake point for several agencies.

Transportation

This service, as provided by MCES, is not generally available elsewhere. Other communities may have arrangements with ambulance companies or, as Montgomery County did prior to MCES, rely on the police. Paraprofessional staff are often used to transport clients but rarely in ambulances. However, in neither of these instances are the transportation staff trained in psychiatric and drug or alcohol emergencies. The transportation service is easily replicated as part of an entire program or simply as a unique component

serving several different facilities.

Criminal Justice Liaison Network

Both the cooperation between the county police agencies and MCES and the pilot program of service workers in the departments are unique. In order for civilians to become involved in enforcement duties, the confidence and respect of the police departments must be earned. MCES has done this in part by involving the criminal justice community in the planning stages, providing them with Board representation, and remaining in close and constant contact with them.

The Facility and In-Patient Services

Few psychiatric hospitals provide the comprehensive emergency services of MCES. Typically, even the psychiatric ward of a general hospital is less equipped to handle emergencies than MCES. An important consideration in replicating MCES is the need for an accredited psychiatric hospital. Only after accreditation can the third party billing procedure, necessary to sustain expenses, be instituted.*

The major advantage to MCES' location in a separate facility is that staff do not become involved with general hospital responsibilities, but are able to devote full time to emergency services. Furthermore, as a separate facility it becomes easier to establish an identity and develop the critical contacts with community services, especially law enforcement. However, certain medical specialists and expertise are available in general hospitals which may occasionally be needed. MCES relies on a neighboring general hospital to provide these services. Additionally, it must be recognized that separate facilities are generally expensive; MCES was fortunate to find a building that could be leased on a dollar per year basis. Also for accreditation, a hospital must have medical, dietary and laundry facilities. MCES was able to subcontract these services with other accredited hospitals; however, this might not always be possible.

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* See Chapter 6 for a discussion of these issues.

The process of converting an already accredited and established psychiatric hospital would be feasible but would require adding the telephone, transportation, CIOT and Criminal Justice Liaison components, all of which are replicable.

Finally, with regard to community size or type, it would seem that MCES could be adapted to most communities. Montgomery County is suburban and in some parts rural. Communities that are larger in area may require two facilities if a central location were more than an hour drive from the boundaries. Similarly, urban areas may require a larger facility or more than one facility to service larger populations.

Nevertheless, regardless of population size the demand for psychiatric care and detoxification is a continuing and often increasing need in many communities. The Montgomery County Emergency Service has developed an approach that efficiently and effectively serves its community. The success of MCES in providing 24-hour emergency services suggests that this design should be considered for replication in other communities.

Chapter 8: Results and Evaluation

The goals established for the Montgomery County Emergency Service are broad and comprehensive. MCES was developed to provide the county with 24-hour services for psychiatric, drug and alcohol emergency cases. These services were to be provided through emergency telephone, transportation, evaluation, detoxification, short-term hospitalization, and referral for aftercare. Recognizing that police officers often are required to handle emergency situations, MCES established a second goal of alleviating police departments of this responsibility in psychiatric and drug or alcohol cases and of training and educating police officers in crisis intervention procedures. In addition, the establishment of a Criminal Justice Liaison Network was to enhance the goal of supplementing police efforts in coping with emergency cases. How has MCES met these goals and how can such goals be measured? This chapter explores the answers to these two questions.

8.1 Results

Contacts, Evaluations and Admissions

Since becoming fully operational in February 1974 (and up to May 30, 1977), MCES has contacted 11,374 clients of which 2,968 resulted in admissions. Of the remainder, 1,598 were evaluations only, and 6,808 were simply contacts (walk-ins or telephone contacts resulting in some referral).

In addition, in August 1976, MCES telephone workers began keeping count of information calls which were not previously logged. These cannot appropriately be deemed contacts because referral, or information, is dispatched without providing an initial consultation.

Between August 1, 1976 and May 30, 1977, the phone service has handled 885 such calls.

Prior to MCES, the only available alternative was a Community Mental Health Center. However, as noted earlier, these facilities were not equipped to handle emergencies. Moreover, most maintain general business hours (9-5 Monday-Friday) and therefore may not be available for referral or detention. Thus, prior to MCES, services for emergency mental patients were either not available at all or were available only on an ad hoc basis. Figure 8.1 confirms the need for 24-hour service. As shown in Figure 8.1, 11 percent of all MCES admissions, 10 percent of all evaluations, and 16 percent of all contacts occurred between 12 midnight and 8:00 a.m. The 4-12 p.m. shift actually had more contacts and evaluations than occurred during the 8 a.m. to 4 p.m. shift, and nearly as many admissions. Weekends account for 25 percent of admissions, 27 percent of evaluations and 29 percent of all contacts. In sum, there is a need for MCES services 24 hours each day of the week.

MCES is prepared to deal with both mental health/mental retardation-related cases as well as drug and alcohol cases. It appears that while both services are required, the majority of MCES clients are MH/MR cases. In the first ten months of 1976, 436 (60 percent) of 728 admissions were MH/MR cases while the rest were drug-related. During the first quarter of 1977, MH/MR cases increased to 64.5 percent (232) of the 360 admissions.

Since 1976 MCES has been forced to refer 94 patients (7.5 percent of patients admitted) to other facilities for lack of bed space. All of those 94 patients received some program benefits while awaiting an appropriate referral (which was made in all cases).

Transportation

Prior to MCES, the only emergency transportation service available to psychiatric, drug or alcohol patients was a police squad car. The transportation component of MCES services was introduced in January 1975 to serve two purposes: first, to alleviate the burden on the police and second, to prevent an incident from being compounded by the inherently tense atmosphere of a police

Figure 8.1
Number of Contacts, Evaluations, and Admissions
According to 8-Hour Shifts

November 1976 – May 1977

Weekdays

Shift	Contacts	Evaluations	Admissions	TOTAL
8:00 a.m. to 4:00 p.m.	170	132	212	514
4:00 p.m. to 12 midnight	226	156	206	588
12 midnight to 8:00 a.m.	77	26	46	149
TOTAL	473	314	464	1251

Weekends

Shift	Contacts	Evaluations	Admissions	TOTAL
8:00 a.m. to 4:00 p.m.	81	42	79	202
4:00 p.m. to 12 midnight	88	56	57	201
12 midnight to 8:00 a.m.	28	18	21	67
TOTAL	197	116	157	470
TOTALS	670	430	621	1721

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transfer. Since beginning the transportation service, the MCES van has logged 30,884 miles for the following:

	No. of Trips
Client pick-up for evaluation	524
Client transportation after referral	389
Transportation for medical emergencies	181
Transportation for clients to social service agencies (for supplementary assistance during treatment)	303

Short-Term Hospitalization

As indicated in earlier chapters, MCES is an accredited psychiatric hospital, having met the stringent requirements of the Joint Commission on the Accreditation of Hospitals (JCAH), as well as other accreditation and inspection organizations. The quality of care is therefore assured to meet established national standards.

From January 1976 through April of 1977, MCES averaged 16.7 patients per day. The total number of patient-days in 1976 was 6101 and, in the first quarter of 1977, there were 2003 patient-days. The average length of stay for patients has decreased somewhat in 1977. While patients currently average 5.8 days at MCES, the 1976 average was 7.0. This is probably due to the introduction of the new law which decreases maximum length of stays for involuntary evaluations from 10 days to 72 hours (see Chapter 3).

It should be noted, however, that the majority of patients at MCES are voluntary. Since the implementation of the new law, 360 patients have been admitted for treatment, of which only 104 (29 percent) were involuntary commitments. Furthermore, between January and October 1976 MCES admitted 728 clients, only 36 of whom were discharged either against MCES advice (after consulting with a psychiatrist) or AWOL (without consulting a psychiatrist). Therefore, over 95 percent of the patients admitted during that period satisfactorily completed emergency treatment.

Referrals

Almost every contact with MCES results in a referral. Regardless of whether the client is admitted, evaluated, or simply seen by an intake staff person, the client is referred to an appropriate service for further care.

The ability of MCES to make the appropriate referral is important, since it is the referral agency that has the ultimate responsibility for treating the problem which gave rise to the emergency. The MCES is well suited to this clearinghouse task. The police liaison network staff has developed extensive contact with various county programs for offenders, including halfway houses and both in-patient and out-patient drug and alcohol facilities. In addition, the intake office is continuously in phone contact with social service agencies throughout the county, often resulting in an MCES admission or referral. Of equal importance, however, is the cooperation engendered by this contact. Thus an agency calling to make a referral on one day may be called to accept one the next. Finally, the MCES affiliation with the County Mental Health Administrator's Office makes it a part of a larger service delivery system that can benefit from as well as contribute to the other components.

In order to insure the appropriateness of its referrals the program undertook a follow-up of patients discharged from MCES during the months of May through October of 1976.* This telephone survey attempted to follow up the 350 patients discharged during that period.

Three hundred and twelve of the 350 cases were involved in referrals. The remaining cases were classified as leaving the facility prior to referral arrangement, inappropriate for referral, or inadequate information available for assessment.

Information regarding 275 of the 312 clients referred was recovered. In the 6-8 weeks after MCES discharge, 192 (72.4 percent) of

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* Through a clerical error, September figures were excluded from the study.

Assisted by a nurse, a doctor examines a newly admitted patient.

these cases were considered as either active (presently in a program, participating in out-patient or in-patient care, etc.), or had completed a program or were appropriately discharged from a facility. Thirty-two (11.6 percent) of these patients were referred to a private psychiatrist, family, or other private arrangements.

Thirty-one (11.3 percent) were classified as "no shows" because they did not appear at the referral agency and refused aftercare appointments and/or referrals. Eight persons left referral agencies against medical advice (one AWOL), five decided not to complete the program, three people following initial involvement discontinued aftercare, two were discharged to a more restrictive setting, one person was transferred and another was discharged because of a threat of violence.

Thus, of the 275 patients on which data were available, 224 (82 percent) were either in treatment or had satisfactorily completed treatment, and therefore appear to have received an appropriate referral. Of the 51 clients whose referrals were unsuccessful, only 20 (7.5 percent) were actual program failures; the other 31 simply did not show.*

Prior to the follow-up study MCES attempted to determine the appropriateness of referrals by randomly selecting 40 agencies to which referrals were made and mailing a questionnaire asking:

1. Was the referral from MCES to you appropriate?
2. Did the patient complete the program or not?
3. What was your prognosis?
4. Was the patient referred elsewhere after completing the program?

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* The telephone survey described above made no effort to determine the rate of repeat admission to MCES. However, as noted in Chapter 4, Section 4.1, the Executive Director reports that between February 1974 and May 1977 approximately one-third of all MCES clients were repeaters. Although no formal analysis of these repeaters has been made, project personnel believe they represent people who fail to take prescribed medication or return to their drinking or drug habit.

5. What is the patient's current living situation?
6. Any additional comments.

Thirty-six of the 40 responded. However, responses to questions 3-6 were too incomplete to analyze. Twenty-eight (77.7 percent) of the 36 considered the referral appropriate; seven could not determine the appropriateness because it was either too early or the patient did not show up and one respondent considered the referral inappropriate.

Crisis Intervention Outreach Team

The primary purpose of CIOT is to prevent emergencies by providing immediate, intensive, on-the-spot support. The Crisis Intervention Outreach Team, between July 1, 1975, and April 30, 1977, handled 247 cases (of which 208 involved psychiatric problems and 39 involved drug and alcohol problems). These cases resulted in 523 home visits, 87 office visits, and 873 telephone consultations. CIOT staffers provided clients with the following services:

CIOT Services	Number of Cases
Consultation	34
Evaluation	56
Evaluation and Referral	49
Evaluation and Counseling	43
Evaluation, Counseling and Referral	34
Follow-up	31

While it is not possible to determine how many actual emergencies were averted through CIOT operations, the following list of dispositions of the 225 CIOT cases which have been closed indicated that only 34 (15.1 percent) required in-patient care, and another 73 (32.4 percent) were receiving out-patient care. Thus, a total of 107 (47.6 percent) of the CIOT cases were serious enough to require some ongoing care. (See Figure 8.2.)

Figure 8.2
Breakdown of CIOT Dispositions

In-patient	
General Hospital	4
MCES	17
Norristown State Hospital	4
Private Hospital	9
Out-patient	
Base Service Units	41
Drug Program	1
Alcohol Program	3
Day Treatment Program	10
Social Service Agency	18
Other	
Criminal Justice System	2
Deceased	1
Private Physician	11
No Referral	105
Medical Doctor	1

Supplementary Police Services

One measure of the extent to which MCES achieves its second goal of supplementing police services is the perception of the police themselves. The project has the overwhelming support of the 59 county police agencies. In addition to letters of endorsement from many of the departments, the Police Chief's Association of Montgomery County (of which all 59 department chiefs are members)

has also strongly endorsed the program. The spirit of that endorsement is captured in the following excerpt:

> ...The Chiefs of Police of Montgomery County wish to commend the Montgomery County MH/MR Emergency Service on the quality and effectiveness of the 24-hour consolidated emergency support services that you are providing to all the police department(s) in the County...
>
> ...(W)e wish to support the existence of the Montgomery County MH/MR Emergency Service and sincerely hope that the program will continue to provide its effective consolidation of 24-hour emergency drug, alcohol and psychiatric support services in Montgomery County.

Another measure of support is the degree to which the police use the services. Between February 1, 1974 and April 30, 1977, 3453 (30 percent) of the 11,243 total MCES contacts were criminal justice referrals.* When admissions only are examined, 41 percent (1206 of 2968) of all admissions were initially referred to MCES by the criminal justice system.** Two important facts are demonstrated by these figures. First, it seems clear that the criminal justice system (the police) are using MCES services to a significant extent. Second, since admissions represent those contacts that are most appropriate for MCES attention it appears that the police are using the services appropriately.

Further, while reduced crime and recidivism is not a stated MCES goal, some reduction in charges can be expected when police divert cases to MCES that they would otherwise have handled on their own. Police (and prosecution) are more likely to refrain from arresting or charging an individual if they are satisfied that the incident in which he was involved was related to a psychiatric, drug or alcohol problem that is being treated by professionals in whom they have confidence. While this does not affect the problem in the short term (as the incident still occurred), reductions in arrests and charges do result in a time saving for police and

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* The majority of "criminal justice" referrals are police referrals. However, the courts, corrections and probation do use the service.

** According to the project approximately 10 to 15 percent of these admissions involved individuals who were intoxicated.

court administrators. Furthermore, the MCES alternative removes the stigma of a criminal record from these clients against whom charges were either not brought or dropped. During the months of June, July, and August 1976, MCES staff examined the 152 criminal justice referrals for potential impact on charges. Their findings are presented in Figure 8.3.

It should be noted that for the category "not officially charged" the offenses were determined by asking the officers who handled the cases what charges could have been brought. One hundred and three (68 percent) of the 152 cases resulted in either no charge or charges being dropped. If the 15 cases in which disposition was not determined are removed from the total, the 103 "no charge or charges dropped" cases represent 75 percent of the total. Furthermore, while exact figures were not presented, the Criminal Justice Liaison Coordinator indicated that many of the 34 cases in which charges were brought were actually offenses for which citations (charges) were issued prior to MCES referral. In addition, he indicated that even when charged, clients participated in MCES services and that participation was considered during sentencing.

Another measure of the MCES ability to supplement county police services is the amount of police time saved by the transportation service. For the 524 calls for evaluation pick-up only, a burden that rested solely with the police in the past, MCES staff logged 970 hours or 121.25 person days between January 1, 1975 and April 30, 1977. Considering that some police departments in the county have as few as four men, this is a significant time savings. Besides reducing the number of hours police are unable to meet their patrol duties, these hours logged by the MCES ambulance represent hours in which a community might otherwise have been without police transportation capability.

In sum, it appears that the police departments within the county are making extensive and appropriate use of the MCES facility.

Figure 8.3
List of Criminal Charges for Those Persons Who Had Contact (Admissions, Evaluations and/or Contacts) with MCES During the Months of June, July, and August, 1976

	Status of Criminal Charges (Breakdown)				
	Number (Total)	Not Officially Charged	Charges Dropped	Officially Charged	Disposition Not Known
Assaults (includes attempted and other)	30	14	12	2	2
Disturbing the peace, trespassing, public intoxication, disorderly conduct, driving while intoxicated	31	9	10	11	1
Violation of probation/parole	29	13	10	5	1
Child abuse, corruption morals of minor, indecent exposure	8	2	1	4	1
Burglary	7	1	1	4	1
Receiving stolen goods, thefts, car theft, retail theft	6	1	2	3	
Drug related (directly)	6	6			
Murder, homicide	4	1		1	2
Attempted rape, sexual assault, open lewdness	3			1	2
Juvenile offenses	3	2		1	
Criminal mischief, trespassing	3	1	2		
Destruction of property, damage	2	1	1		
Escape from a correctional facility	2	1	1		
Breaking and entering	1		1		
Involuntary manslaughter	1		1		
Kidnapping	1			1	
Possessing instrument of crime, possession of offensive weapon				1	
Non-support	1	1			
Defrauding an innkeeper	1				1
Arson and bombing	1		1		
TOTAL	152	54	49	34	15

8.2 Evaluation

An evaluation of MCES in terms of the impact which it does or does not have on client behavior and its effect on the criminal justice/mental health system is constrained by at least three factors: the process-oriented goals of the organization; the lack of similarly structured organizations for purposes of comparison; and the feasibility of developing a control group of potential clients who are not directed to MCES.

The Project's goals relate entirely to the process of delivering certain services and not to their potential impact on crime rates or recidivism. Considering the short-term nature of the MCES services, these limited goals seem appropriate. The average stay of patients is only five days and involuntary patients cannot remain more than 72 hours except for the few cases which are extended to 20 days (303 hearings) and remain at MCES while awaiting transfer. This short stay is in keeping with the overall intent to provide emergency service. The primary responsibility of the project is to diagnose, stabilize, and refer. Treatment, while ultimately important, can only begin after the emergency has passed and is therefore considered to be the combined job of MCES and the agency to which patients are referred. Since MCES has established primarily process goals, the measures of success are whether or not the services are in fact being delivered, to what extent they are being delivered, whether they would be available in the program's absence, and the degree to which the police use the services.

Further, MCES provides a unique service in Montgomery County. Indeed, there appear to be few, if any, organizations nationally that compare with the structure, administration and operations of MCES. In the absence of a comparable sample, MCES must be assessed in terms of its contribution to the community, and not in terms of its relative effectiveness or efficiency.

Finally, an evaluation of MCES' impact on client behavior and the criminal justice system is restricted by the infeasibility of developing a control group of individuals who, though eligible for MCES services, are randomly chosen to be denied those services. Since all 59 police departments in the county now refer eligible persons to MCES, and since MCES has rejected a negligible number for lack of space even a non-randomly selected control group of eligible MCES patients is unavailable.

8.3 Monitoring Operations

Except for the ongoing evaluation by the accreditation groups of the quality of the psychiatric services provided (see Chapter 6), the Program's research is limited to the tabulations and monitoring efforts involved in documenting the results set forth in Section 8.1 above. Since it is critical for a service delivery program to keep abreast of the need for its services, in this instance by clients as well as police and other agencies, MCES has developed extensive monitoring activities. These activities extend to all phases of the Program and serve as administrative tools for determining the community's changing needs, allocating program resources, and assessing the effectiveness of particular program components.

Tracking the number of contacts, evaluations and admissions by time of day is a simple process but necessary for scheduling shifts and the allocation of project resources. Other more complex monitoring efforts are designed for criminal justice liaison and client referral.

The criminal justice liaison is a crucial concern that requires constant monitoring because of the role played by the police in referring clients as well as their overall posture in the community as crisis intervenors. The ultimate test of criminal justice liaison activity is police confidence which will best be measured by the level of use. This can be both maintained and carefully monitored by scheduled "rounds" with the various departments. It would also seem that the willingness of the police to engage in intervention training with program instructors and to allow liaison workers to be placed in their departments are sure signs of police cooperation and confidence.

Because the program's role is primarily to diagnose, stabilize and refer, it is critical that its referrals are appropriate. Ultimately, outcomes will be determined by the treatment process which is entirely dependent upon the diagnosis and resultant assignment to treatment. The approach taken by MCES is simple and straightforward. All referrals, or a randomly selected sample of referrals, are followed up by questionnaires or phone calls to determine whether the agency receiving the referral considered it appropriate and whether (and how long) the client remained in treatment. Together with a similar questionnaire for the referred clients, the

project can assess both client satisfaction and treatment effectiveness of its referrals.

Finally, another useful mechanism for analyzing the appropriateness of MCES treatment and referrals would be a follow-up of all repeat admissions. By comparing the most current diagnosis with repeaters' previous diagnoses and intervening treatment, the project may be able to learn why a particular problem persists and whether previous referrals were effective. Further, by analyzing the case histories of repeaters MCES may be able to devise and/or recommend remedial measures to its referral agencies.

Appendix A
Pennsylvania Mental Health Procedures Act of 1976

ARTICLE I[1]

General Provisions

Section 101. Short Title.

This act shall be known and may be cited as the "Mental Health Procedures Act."

Section 102. Statement of Policy

It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness.

Section 103. Scope of Act

This act establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. "Inpatient treatment" shall include all treatment that requires full or part-time residence in a facility. For the purpose of this act, a "facility" means any mental health establishment, hospital, clinic, institution, center, day care center, base service unit, community mental health center, or part thereof, that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, whether as outpatients or inpatients.

Section 104. Provision for Treatment

Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his recovery from mental illness. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial

1. 50 P.S. §§7101 to 7115.

hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary facilities, clothing, recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions.

Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness and shall also include care and other services that supplement treatment and aid or promote such recovery.

Section 105. Treatment Facilities

Involuntary treatment and voluntary treatment funded in whole or in part by public moneys shall be available at a facility approved for such purposes by the county administrator (who shall be the County Mental Health and Mental Retardation Administrator of a county or counties, or his duly authorized delegate) or by the Department of Public Welfare, hereinafter cited as the "department." Approval of facilities shall be made by the appropriate authority which can be the department pursuant to regulations adopted by the department. Treatment may be ordered at the Veterans Administration or other agency of the United States upon receipt of a certificate that the person is eligible for such hospitalization or treatment and that there is available space for his care. Mental health facilities operated under the direct control of the Veterans Administration or other Federal agency are exempt from obtaining State approval. The department's standards for approval shall be at least as stringent as those of the joint commission for accreditation of hospitals and those of the Federal Government pursuant to Titles 18 and 19 of the Federal Social Security Act[2] to the extent that the type of facility is one in which those standards are intended to apply. An exemption from the standards may be granted by the department for a period not in excess of one year and may be renewed. Notice of each exemption and the rationale for allowing the exemption must be published pursuant to the act of July 31, 1968 (P.L. 769, No. 240), known as the "Commonwealth Documents Law,"[3] and shall be prominently posted at the entrance to the main office and in the reception areas of the facility.

2. 42 U.S.C.A. §§1395 et seq. 1396 et seq.
3. 45 P.S. §1101 et seq.

Section 106. Persons Responsible for Formulation and Review of Treatment Plan

(a) Pursuant to sections 107 and 108 of this act,[4] a treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under this act.

(b) A treatment team must be under the direction of either a physician or a licensed clinical psychologist and may include other mental health professionals.

(c) A treatment team must be under the direction of a physician when:

(1) failure to do so would jeopardize Federal payments made on behalf of a patient; or

(2) the director of a facility requires the treatment to be under the direction of a physician.

(d) All treatment teams must include a physician and the administration of all drugs shall be controlled by the act of April 14, 1972 (P.L. 233, No. 64), known as "The Controlled Substance, Drug, Device and Cosmetic Act."[5]

Section 107. Individualized Treatment Plan

Individualized treatment plan means a plan of treatment formulated for a particular person in a program appropriate to his specific needs. To the extent possible, the plan shall be made with the cooperation, understanding and consent of the person in treatment, and shall impose the least restrictive alternative consistent with affording the person adequate treatment for his condition.

Section 108. Periodic Reexamination, Review and Redisposition

(a) Reexamination and Review. Every person who is in treatment under this act shall be examined by a treatment team and his treatment plan reviewed not less than once in every 30 days.

(b) Redisposition. On the basis of reexamination and review, the treatment team may either authorize continuation of the existing treatment plan if appropriate, formulate a new individualized treatment plan, or recommend to the director the discharge of the person. A person shall not remain in treatment or under any particular mode of treatment for longer than such treatment is necessary and appropriate to his needs.

4. 50 P.S. §§7107, 7108.
5. 35 P.S. §780-101 et seq.

(c) Record of Reexamination and Review. The treatment team responsible for the treatment plan shall maintain a record of each reexamination and review under this section for each person in treatment to include:

(1) a report of the reexamination, including a diagnosis and prognosis;

(2) a brief description of the treatment provided to the person during the period preceding the reexamination and the results of that treatment;

(3) a statement of the reason for discharge or for continued treatment;

(4) an individualized treatment plan for the next period, if any;

(5) a statement of the reasons that such treatment plan imposes the least restrictive alternative consistent with adequate treatment of his condition; and

(6) a certification that the adequate treatment recommended is available and will be afforded in the treatment program.

Section 109. Mental Health Review Officer

Legal proceedings concerning extended involuntary emergency treatment under section 303(c)[6], or court-ordered involuntary treatment under section 304[7], may be conducted by a judge of the court of common pleas or by a mental health review officer authorized by the court to conduct the proceedings. Mental health review officers shall be members of the bar of the Supreme Court of Pennsylvania, without restriction as to the county of their residence and where possible should be familiar with the field of mental health. They shall be appointed by the respective courts of common pleas for terms not to exceed one year, and may be reappointed to successive terms.

Section 110. Written Applications, Petitions, Statements and Certifications

(a) All written statements pursuant to section 302(a), (2)[8], and all applications, petitions, and certifications required under the provisions of this act shall be made subject to the penalities provided under 18 Pa.C.S. §4904 (relating to unsworn falsification to authorities) and shall contain a notice to that effect.

6. 50 P.S. §7303(c).
7. 50 P.S. §7304.
8. 50 P.S. §7302(a)(2).

(b) All such applications, petitions, statements and certifications shall be filed with the county administrator in the county where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides.

Section 111. Confidentiality of Records

All documents concerning persons in treatment shall be kept confidential and, without the person's written consent, may not be released or their contents disclosed to anyone except:

(1) those engaged in providing treatment for the person;

(2) the county administrator, pursuant to section 110[9];

(3) a court in the course of legal proceedings authorized by this act; and

(4) pursuant to Federal rules, statutes and regulations governing disclosure of patient information where treatment is undertaken in a Federal agency.

In no event, however, shall privileged communications, whether written or oral, be disclosed to anyone without such written consent. This shall not restrict the collection and analysis of clinical or statistical data by the department, the county administrator or the facility so long as the use and dissemination of such data does not identify individual patients. Nothing herein shall be construed to conflict with section 8 of the act of April 14, 1972 (P.L. 221, No. 63) known as the "Pennsylvania Drug and Alcohol Abuse Control Act."[10]

Section 112. Rules, Regulations and Forms

The department shall adopt such rules, regulations and forms as may be required to effectuate the provisions of this act. Rules and regulations adopted under the provisions of this act shall be adopted according to provisions of section 201 of the act of October 20, 1966 (3rd Sp.Sess. P.L. 96, No. 6), known as the "Mental Health and Mental Retardation Act of 1966,"[11] and the act of July 31, 1968 (P.L. 769, No. 240), known as the "Commonwealth Documents Law."[12]

Section 113. Rights and Remedies of a Person in Treatment

Every person who is in treatment shall be entitled to all other

9. 50 P.S. §7110.
10. 71 P.S. §1690.108.
11. 50 P.S. §4201.
12. 45 P.S. §1101 et seq.

rights now or hereafter provided under the laws of this Commonwealth, in addition to any rights provided for in this act. Actions requesting damages, declaratory judgment, injunction, mandamus, writs of prohibition, habeas corpus, including challenges to the legality of detention or degree of restraint, and any other remedies or relief granted by law may be maintained in order to protect and effectuate the rights granted under this act.

Section 114. Immunity from Civil and Criminal Liability

(a) In the absence of willfull misconduct or gross negligence, a county administrator, a director of a facility, a physician or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under the partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

(b) A judge or a mental health review officer shall not be civilly or criminally liable for any actions taken or decisions made by him pursuant to the authority conferred by this act.

Section 115. Venue and Location of Legal Proceedings

(a) The jurisdiction of the courts of common pleas and juvenile courts conferred by Articles II and III[13] shall be exercised initially by the court for the county in which the subject of the proceedings is or resides. Whenever involuntary treatment is ordered, jurisdiction over any subsequent proceeding shall be retained by the court on which the initial proceedings took place, but may be transferred to the county of the person's usual residence. In all cases, a judge of the court of common pleas or a mental health review officer of the county of venue may conduct legal proceedings at a facility where the person is in treatment whether or not its location is within the county.

(b) Venue for actions instituted to effectuate rights under this act shall be as now or hereafter provided by law.

13. 50 P.S. §7201 to 7306.

ARTICLE II[14]

Voluntary Examination and Treatment

Section 201. Persons Who May Authorize Voluntary Treatment

Any person 14 years of age or over who believes that he is in need of treatment and substantially understands the nature of voluntary commitment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily. A parent, guardian, or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in doing so shall be deemed to be acting for the child. Except as otherwise authorized in this act, all of the provisions of this act governing examination and treatment shall apply.

Section 202. To Whom Application May be Made

Application for voluntary examination and treatment shall be made to an approved facility or to the county administrator, Veterans Administration or other agency of the United States operating a facility for the care and treatment of mental illness. When application is made to the county administrator, he shall designate the approved facility for examination and for such treatment as may be appropriate.

Section 203. Explanation and Consent

Before a person is accepted for voluntary inpatient treatment, an explanation shall be made to him of such treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject, together with a statement of his rights under this act. Consent shall be given in writing upon a form adopted by the department. The consent shall include the following representations: That the person understands his treatment will involve inpatient status; that he is willing to be admitted to a designated facility for the purpose of such examination and treatment; and that he consents to such admission voluntarily, without coercion or duress; and, if applicable, that he has voluntarily agreed to remain in treatment for a specified period of no longer than 72 hours after having given written notice of his intent to withdraw from treatment. The consent shall be part of the person's record.

14. 50 P.S. §§7201 to 7207.

Section 204. Notice to Parents

Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents, guardian, or person standing in loco parentis, and shall inform them of the right to be heard upon the filing of an objection. Whenever such objection is filed, a hearing shall be held within 72 hours by a judge or mental health review officer, who shall determine whether or not the voluntary treatment is in the best interest of the minor.

Section 205. Physical Examination and Formulation of Individualized Treatment Plan

Upon acceptance of a person for voluntary examination and treatment he shall be given a physical examination. Within 72 hours after acceptance of a person an individualized treatment plan shall be formulated by a treatment team. The person shall be advised of the treatment plan, which shall become a part of his record. The treatment plan shall state whether in-patient treatment is considered necessary, and what restraints or restrictions, if any, will be administered, and shall set forth the bases for such conclusions.

Section 206. Withdrawal from Voluntary Inpatient Treatment

(a) A person in voluntary inpatient treatment may withdraw at any time by giving written notice unless, as stated in section 203[15], he has agreed in writing at the time of his admission that his release can be delayed following such notice for a period to be specified in the agreement, provided that such period shall not exceed 72 hours.

(b) If the person is under the age of 14, his parent, legal guardian, or person standing in loco parentis may affect his release. If any responsible party believes that it would be in the best interest of a person under 14 years of age in voluntary treatment to be withdrawn therefrom or afforded treatment constituting a less restrictive alternative, such party may file a petition in the Juvenile Division of the court of common pleas for the county in which the person under 14 years of age resides, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for such minor person and schedule a hearing to determine what inpatient treatment, if any, is in the minor's best interest.

15. 50 P.S. §7203.

The hearing shall be held within ten days of receipt of the petition, unless continued upon the request of the attorney for such minor. The hearing shall be conducted in accordance with the rules governing other Juvenile Court proceedings.

(c) Nothing in this act shall be construed to require a facility to continue inpatient treatment where the director of the facility determines such treatment is not medically indicated. Any dispute between a facility and a county administrator as to the medical necessity for voluntary inpatient treatment of a person shall be decided by the Commissioner of Mental Health or his designate.

Section 207. Transfer of Person in Voluntary Treatment

A person who is in voluntary treatment may not be transferred from one facility to another without his written consent.

ARTICLE III[16]

Involuntary Examination and Treatment

Section 301. Persons Who May be Subject to Involuntary Emergency Examination and Treatment

(a) Persons Subject.--Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(b) Determination of Clear and Present Danger.--(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and

16. 50 P.S. §§7301 to 7306.

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present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act; or

(iii) the person has severely mutilated himself or attempted to mutilate himself severely and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act.

Section 302. Involuntary Emergency Examination and Treatment Authorized by a Physician--Not to Exceed Seventy-Two Hours

(a) Application for Examination--Emergency examination may be undertaken at a treatment facility upon the certification of a physician stating the need for such examination; or upon a warrant issued by the county administrator authorizing such examination; or without a warrant upon application by a physician or other authorized person who has personally observed conduct showing the need for such examination.

(1) Warrant for Emergency Examination--Upon written application by a physician or other responsible party setting forth facts constituting reasonable grounds to believe a person is severely mentally disabled and in need of immediate treatment, the county administrator may issue a warrant requiring a person authorized by him, or any peace officer, to take such person to the facility specified in the warrant.

(2) Emergency Examination Without a Warrant--Upon personal observation of the conduct of a person constituting reasonable grounds to believe that he is severely mentally disabled and in need of immediate treatment, any physician or peace officer, or anyone authorized by the county administrator may take such person to an approved facility for an emergency examination.

Upon arrival, he shall make a written statement setting forth the grounds for believing the person to be in need of such examination.

(b) Examination and Determination of Need for Emergency Treatment.--A person taken to a facility shall be examined by a physician within two hours of arrival in order to determine if the person is severely mentally disabled within the meaning of section 301[17] and in need of immediate treatment. If it is determined that the person is severely mentally disabled and in need of emergency treatment, treatment shall be begun immediately. If the physician does not so find, or if at any time it appears there is no longer a need for immediate treatment, the person shall be discharged and returned to such place as he may reasonably direct. The physician shall make a record of the examination and his findings. In no event shall a person be accepted for involuntary emergency treatment if a previous application was granted for such treatment and the new application is not based on behavior occurring after the earlier application.

(c) Notification of Rights at Emergency Examination.--Upon arrival at the facility, the person shall be informed of the reasons for emergency examination and of his right to communicate immediately with others. He shall be given reasonable use of the telephone. He shall be requested to furnish the names of parties whom he may want notified of his custody and kept informed of his status. The county administrator or the director of the facility shall:

(1) give notice to such parties of the whereabouts and status of the person, how and when he may be contacted and visited, and how they may obtain information concerning him while he is in inpatient treatment; and

(2) take reasonable steps to assure that while the person is detained, the health and safety needs of any of his dependents are met, and that his personal property and the premises he occupies are secure.

(d) Duration of Emergency Examination and Treatment.--A person who is in treatment pursuant to this section shall be discharged whenever it is determined that he no longer is in need of treatment and in any event within 72 hours, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202 of this act[18]; or

(2) a certification for extended involuntary emergency treatment is filed pursuant to section 303 of this act.

17. 50 P.S. §7301.
18. 50 P.S. §7202.

Section 303. Extended Involuntary Emergency Treatment Certified by a Judge or Mental Health Review Officer--Not to Exceed Twenty Days

(a) Persons Subject to Extended Involuntary Treatment.--Application for extended involuntary emergency treatment may be made for any person who is being treated pursuant to section 302[19] whenever the facility determines that the need for emergency treatment is likely to extend beyond 72 hours. The application shall be filed forthwith in the court of common pleas, and shall state the grounds on which extended emergency treatment is believed to be necessary. The application shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(b) Appointment of Counsel and Scheduling of Informal Hearing.--Upon receiving such application, the court of common pleas shall appoint an attorney who shall represent the person unless it shall appear that the person can afford, and desires to have, private representation. Within 24 hours after the application is filed, an informal hearing shall be conducted by a judge or by a mental health review officer and, if practicable, shall be held at the facility.

(c) Informal Hearing on Extended Emergency Treatment Application.--(1) At the commencement of the informal hearing, the judge or the mental health review officer shall inform the person of the nature of the proceedings. Information relevant to whether the person is severely mentally disabled and in need of treatment shall be reviewed, including the reasons that continued involuntary treatment is considered necessary. Such explanation shall be made by a physician who examined the person and shall be in terms understandable to a layman. The person or his representative shall have the right to ask questions of the physician and of any other witnesses and to present any relevant information. At the conclusion of the review, if the judge or the review officer finds that the person is severely mentally disabled and in need of continued involuntary treatment, he shall so certify. Otherwise, he shall direct that the facility director or his designee discharge the person.

(2) A stenographic or other sufficient record of the proceedings shall be made. Such record shall be kept by the court or mental health review officer for at least one year.

(d) Contents of Certification.--A certification for extended involuntary treatment shall be made in writing upon a form adopted by the department and shall include:

19. 50 P.S. §7302.

(1) findings by the judge or mental health review officer as to the reasons that extended involuntary emergency treatment is necessary;

(2) a description of the treatment to be provided together with an explanation of the adequacy and appropriateness of such treatment, based upon the information received at the hearing;

(3) any documents required by the provisions of section 302[20];

(4) the application as filed pursuant to section 303(a)[21];

(5) a statement that the person is represented by counsel; and

(6) an explanation of the effect of the certification, the person's right to petition the court for release under subsection (g), and the continuing right to be represented by counsel.

(e) Filing and Service.--The certification shall be filed with the director of the facility and a copy served on the person, such other parties as the person requested to be notified pursuant to section 302(c)[22], and on counsel.

(f) Effect of Certification.--Upon the filing and service of a certification for extended involuntary emergency treatment, the person may be given treatment in an approved facility for a period not to exceed 20 days.

(g) Petition to Common Pleas Court.--In all cases in which the hearing was conducted by a mental health review officer, a person made subject to treatment pursuant to this section shall have the right to petition the court of common pleas for review of the certification. A hearing shall be held within 72 hours after the petition is filed unless a continuance is requested by the person's counsel. The hearing shall include a review of the certification and such evidence as the court may receive or require. If the court determines that further involuntary treatment is necessary and that the procedures prescribed by this act have been followed, it shall deny the petition. Otherwise, the person shall be discharged.

(h) Duration of Extended Involuntary Emergency Treatment.--Whenever a person is no longer severely mentally disabled or in need of immediate treatment and, in any event, within 20 days after the filing of the certification, he shall be discharged, unless within such period:

(1) he is admitted to voluntary treatment pursuant to section 202[23];

20. 50 P.S. §7302
21. 50 P.S. §7303(a)
22. 50 P.S. §7302(c)
23. 50 P.S. §7202

(2) the court orders involuntary treatment pursuant to section 304[24].

Section 304. Court-ordered Involuntary Treatment Not to Exceed Ninety Days

(a) Persons for Whom Application May be Made.--(1) A person who is severely mentally disabled and in need of treatment, as defined in section 301(a)[25], may be made subject to court-ordered involuntary treatment upon a determination of clear and present danger under section 301(b)(1) (serious bodily harm to others), or section 301(b)(2)(i) (inability to care for himself, creating a danger of death or serious harm to himself), or 301(b)(2)(ii) (attempted suicide), or 301(b)(2)(iii) (self-mutilation).

(2) Where a petition is filed for a person already subject to involuntary treatment, it shall be sufficient to represent, and upon hearing to reestablish, that the conduct originally required by section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurrence of dangerous conduct, either harmful or debilitating, within the past 30 days.

(b) Procedures for Initiating Court-order Involuntary Treatment for Persons Already Subject to Involuntary Treatment.--(1) Petition for court-ordered involuntary treatment for persons already subject to treatment under sections 303 and 305 may be made by the county administrator to the court of common pleas.

(2) The petition shall be in writing upon a form adopted by the department and shall include a statement of the facts constituting reasonable grounds to believe that the person is severely mentally disabled and in need of treatment. The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person. It shall also state that the person has been given the information required by subsection (b)(3) and shall include copies of all documents relating to examination and treatment of the person which are required under this act.

(3) Upon the filing of the petition the county administrator shall serve a copy on the person, his attorney, and those designated to be kept informed, as provided in section 302(c)[26], including an explanation of the nature of the proceedings, the

24. 50 P.S. §7304.
25. 50 P.S. §7301(a).
26. 50 P.S. §7302(c).

person's right to an attorney and the services of an expert in the field of mental health, as provided by subsection (d).

(4) A hearing on the petition shall be held in all cases, not more than five days after the filing of the petition.

(5) Treatment shall be permitted to be maintained pending the determination of the petition.

(c) Procedures for Initiating Court-ordered Involuntary Treatment for Persons not in Involuntary Treatment.--(1)Any responsible party may file a petition in the court of common pleas requesting court-ordered involuntary treatment for any person not already in involuntary treatment for whom application could be made under subsection (a).

(2) The petition shall be in writing upon a form adopted by the department and shall set forth facts constituting reasonable grounds to believe that the person is within the criteria for court-ordered treatment set forth in subsection (a). The petition shall state the name of any examining physician and the substance of his opinion regarding the mental condition of the person.

(3) Upon a determination that the petition sets forth such reasonable cause, the court shall appoint an attorney to represent the person and set a date for the hearing as soon as practicable. The attorney shall represent the person unless it shall appear that he can afford, and desires to have, private representation.

(4) The court, by summons, shall direct the person to appear for a hearing. The court may issue a warrant directing the person authorized by the county administrator or a peace officer to bring such person before the court at the time of the hearing if there are reasonable grounds to believe that the person will not appear voluntarily. A copy of the petition shall be served on such person at least three days before the hearing together with a notice advising him that an attorney has been appointed who shall represent him unless he obtains an attorney himself, that he has a right to be assisted in the proceedings by an expert in the field of mental health, and that he may request or be made subject to psychiatric examination under subsection (c) (5).

(5) Upon motion of either the petitioner or the person, or upon its own motion, the court may order the person to be examined by a psychiatrist appointed by the court. Such examination shall be conducted on an outpatient basis, and the person shall have the right to have counsel present. A report of the examination shall be given to the court and counsel at least 48 hours prior to the hearing.

(6) Involuntary treatment shall not be authorized during the pendency of a petition except in accordance with section 302 or

section 303.[27]

(d) Professional Assistance.--A person with respect to whom a hearing has been ordered under this section shall have and be informed of a right to employ a physician, clinical psychologist or other expert in mental health of his choice to assist him in connection with the hearing and to testify on his behalf. If the person cannot afford to engage such a professional, the court shall, on application, allow a reasonable fee for such purpose. The fee shall be a charge against the mental health and mental retardation program of the locality.

(e) Hearings on Petition for Court-ordered Involuntary Treatment.--A hearing on a petition for court-ordered involuntary treatment shall be conducted according to the following:

(1) The person shall have the right to counsel and to the assistance of an expert in mental health.

(2) The person shall not be called as a witness without his consent.

(3) The person shall have the right to confront and cross-examine all witnesses and to present evidence in his own behalf.

(4) The hearing shall be public unless it is requested to be private by the person or his counsel.

(5) A stenographic or other sufficient record shall be made, which shall be impounded by the court and may be obtained or examined only upon the request of the person or his counsel or by order of the court on good cause shown.

(6) The hearing shall be conducted by a judge or by a mental health review officer and may be held at a location other than a courthouse when doing so appears to be in the best interest of the person.

(7) A decision shall be rendered within 48 hours after the close of evidence.

(f) Determination and Order.--Upon a finding by clear and convincing evidence that the person is severely mentally disabled and in need of treatment and subject to subsection (a), an order shall be entered directing treatment of the person in an approved facility as an inpatient or an outpatient. Inpatient treatment shall be deemed appropriate only after full consideration has been given to less restrictive alternatives. Investigation of treatment alternatives shall include consideration of the person's relationship to his community and family, his employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment shall include findings on this issue.

27. 50 P.S. §7302, 7303.

(g) Duration of Court-ordered Involuntary Treatment.--(1) A person may be made subject to court-ordered involuntary treatment under this section for a period not to exceed 90 days, excepting only that: Persons may be made subject to court-ordered involuntary treatment under this section for a period not to exceed one year if:

(i) severe mental disability is based on acts giving rise to the following charges under the Pennsylvania Crimes Code[28]: murder (§ 2502); voluntary manslaughter (§ 2503); aggravated assault (§ 2702); kidnapping (§ 2901); rape (§ 3121(1) and (3)); involuntary deviate sexual intercourse (§ 3123(1) and (2)); and

(ii) a finding of incompetency to be tried or a verdict of acquittal because of lack of criminal responsibility has been entered.

(2) If at any time the director of a facility concludes that the person is not severely mentally disabled or in need of treatment pursuant to subsection (a), he shall discharge the person.

Section 305. Additional Periods of Court-ordered Involuntary Treatment

At the expiration of a period of court-ordered involuntary treatment under section 304(g)[29], the court may order treatment for an additional period upon the application of the county administrator or the director of the facility in which the person is receiving treatment. Such order shall be entered upon hearing on findings as required by sections 304(a) and (b), and the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment. A person found dangerous to himself under section 301(b)(2)(i), (ii) or (iii)[30] shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative. This limitation shall not apply where, upon application made by the county administrator or facility director, it is determined by a judge or mental health review officer that such release would not be in the person's best interest.

Section 306. Transfer of Persons in Involuntary Treatment

Person in involuntary treatment pursuant to this act may be transferred to any approved facility. Whenever such transfer

28. 18 Pa.C.S.A.
29. 50 P.S. § 7304(g).
30. 50 P.S. § 7301.

will constitute a greater restraint, it shall not take place unless, upon hearing, a judge or mental health review officer finds it to be necessary and appropriate.

ARTICLE IV[31]

Determinations Affecting Those Charged With Crime or Under Sentence

Section 401. Examination and Treatment of a Person Charged with Crime or Serving Sentence

(a) Examination and Treatment to be Pursuant to Civil Provisions.--Whenever a person who is charged with crime, or who is undergoing sentence, is or becomes severely mentally disabled, proceedings may be instituted for examination and treatment under the civil provisions of this act in the same manner as if he were not so charged or sentenced. Proceedings under this section shall not be initiated for examination and treatment at Veterans Administration facilities if such examination and treatment requires the preparation of competency reports and/or the facility is required to maintain custody and control over the person. Such proceedings, however, shall not affect the conditions of security required by his criminal detention or incarceration.

(b) Status in Involuntary Treatment.--Whenever a person who is detained on criminal charges or is incarcerated is made subject to inpatient examination or treatment, he shall be transferred, for this purpose, to a mental health facility. Transfer may be made to a Veterans Administration facility provided that neither custody nor control are required in addition to examination and treatment. Such individuals transferred to the Veterans Administration are not subject to return by the Federal agency to the authority entitled to have them in custody. During such period, provisions for his security shall continue to be enforced, unless in the interim a pretrial release is effected, or the term of imprisonment expires or is terminated, or it is otherwise ordered by the court having jurisdiction over his criminal status. Upon discharge from treatment, a person who is or remains subject to a detainer or sentence shall be returned to the authority entitled to have him in custody. The period of involuntary treatment shall be credited as time served on account of any sentence to be imposed on pending charges or any unexpired term of imprisonment.

(c) Persons Subject to the Juvenile Act.--As to any person who

31. 50 P.S. §§ 7401 to 7406.

is subject to a petition or who has been committed under the Juvenile Act[32], the civil provisions of this act applicable to children of his age shall apply to all proceedings for his examination and treatment. If such a person is in detention or is committed, the court having jurisdiction under the Juvenile Act shall determine whether such security conditions shall continue to be enforced during any period of involuntary treatment and to whom the person should be released thereafter.

Section 402. Incompetence to Proceed on Criminal Charges and Lack of Criminal Responsibility as Defense

(a) Definition of Incompetency.--Whenever a person who has been charged with a crime is found to be substantially unable to understand the nature or object of the proceedings against him or to participate and assist in his defense, he shall be deemed incompetent to be tried, convicted or sentenced so long as such incapacity continues.

(b) Involuntary Treatment of Persons Found Incompetent to Stand Trial Who are Not Mentally Disabled.--Notwithstanding the provisions of article III of this act[33], a court may order involuntary treatment of a person found incompetent to stand trial but who is not severely mentally disabled, such involuntary treatment not to exceed a specific period of 30 days. Involuntary treatment pursuant to this subsection may be ordered only if the court is reasonably certain that the involuntary treatment will provide the defendant with the capacity to stand trial. The court may order outpatient treatment, partial hospitalization or inpatient treatment.

(c) Application for Incompetency Examination.--Application to the court for an order directing an incompetency examination may be presented by an attorney for the Commonwealth, a person charged with a crime, his counsel, or the warden or other official in charge of the institution or place in which he is detained. A person charged with crime shall be represented either by counsel of his selection or by court-appointed counsel.

(d) Hearing; When Required.--The court, either on application or on its own motion, may order an incompetency examination at any stage in the proceedings and may do so without a hearing unless the examination is objected to by the person charged with a crime or by his counsel. In such event, an examination shall be ordered only after determination upon a hearing that there is a prima facie question of incompetency.

32. 11 P.S. § 50-101 et seq.
33. 50 P.S. §§ 7301 to 7306.

(e) Conduct of Examination; Report.--When ordered by the court, an incompetency examination shall take place under the following conditions:

(1) It shall be conducted as an outpatient examination unless an inpatient examination is, or has been, authorized under another provision of this act.

(2) It shall be conducted by at least one psychiatrist and may relate both to competency to proceed and to criminal responsibility for the crime charged.

(3) The person shall be entitled to have counsel present with him and shall not be required to answer any questions or to perform tests unless he has moved for or agreed to the examination. Nothing said or done by such person during the examination may be used as evidence against him in any criminal proceedings on any issue other than that of his mental condition.

(4) A report shall be submitted to the court and to counsel and shall contain a description of the examination, which shall include:

(i) diagnosis of the person's mental condition;

(ii) an opinion as to his capacity to understand the nature and object of the criminal proceedings against him and to assist in his defense;

(iii) when so requested, an opinion as to his mental condition in relation to the standards for criminal responsibility as then provided by law if it appears that the facts concerning his mental condition may also be relevant to the question of legal responsibility; and

(iv) when so requested, an opinion as to whether he had the capacity to have a particular state of mind, where such state of mind is a required element of the criminal charge.

(f) Experts.--The court may allow a psychiatrist retained by the defendant or the prosecution to witness and participate in the examination. Whenever a defendant who is financially unable to retain such expert has a substantial objection to the conclusions reached by the court-appointed psychiatrist, the court shall allow reasonable compensation for the employment of a psychiatrist of his selection, which amount shall be chargeable against the mental health and mental retardation program of the locality.

(g) Time Limit on Determination.--The determination of the competency of a person who is detained under a criminal charge shall be rendered by the court within 20 days after the receipt of the report of examination unless the hearing was continued at the person's request.

Section 403. Hearing and Determination of Incompetency to Proceed; Stay of Proceedings; Dismissal of Charges

(a) Competency Determination and Burden of Proof.--The moving party shall have the burden of establishing incompetency to proceed by clear and convincing evidence. The determination shall be made by the court.

(b) Effect as Stay--Exception.--A determination of incompetency to proceed shall effect a stay of the prosecution for so long as such incapacity persists, excepting that any legal objections suitable for determination prior to trial and without the personal participation of the person charged may be raised and decided in the interim.

(c) Defendant's Right to Counsel; Reexamination.--A person who is determined to be incompetent to proceed shall have a continuing right to counsel so long as the criminal charges are pending. Following such determination, the person charged shall be reexamined not less than every 60 days by a psychiatrist appointed by the court and a report of reexamination shall be submitted to the court and to counsel.

(d) Effect on Criminal Detention.--Whatever a person who has been charged with a crime has been determined to be incompetent to proceed, he shall not for that reason alone be denied pretrial release. Nor shall he in any event be detained on the criminal charge longer than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If the court determines there is no such probability, it shall discharge the person. Otherwise, he may continue to be criminally detained so long as such probability exists but in no event longer than the period of time specified in subsection (f).

(e) Resumption of Proceedings or Dismissal.--When the court, on its own motion or upon the application of the attorney for the Commonwealth or counsel for the defendant, determines that such person has regained his competence to proceed, the proceedings shall be resumed. If the court is of the opinion that by reason of the passage of time and its effect upon the criminal proceedings it would be unjust to resume the prosecution, the court may dismiss the charge and order the person discharged.

(f) Stay of Proceedings.--In no instance shall the proceedings be stayed for a period in excess of the maximum sentence that may be imposed for the crime or crimes charged, or five years, whichever is less.

Section 404. Hearing and Determination of Criminal Responsibility; Bifurcated Trial.

(a) Criminal Responsibility Determination by Court.--At a hearing under section 403 of the act[34] the court may, in its discretion, also hear evidence on whether the person was criminally responsible for the commission of the crime charged. It shall do so in accordance with the rules governing the consideration and determination of the same issue at criminal trial. If the person is found to have lacked criminal responsibility, an acquittal shall be entered. If the person is not so acquitted, he may raise the defense at such time as he may be tried.

(b) Opinion Evidence on Mental Condition.--At a hearing under section 403 or upon trial, a psychiatrist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or other expert to testify.

(c) Bifurcation of Issues or Trial.--Upon trial, the court, in the interest of justice, may direct that the issue of criminal responsibility be heard and determined separately from the other issues in the case and, in a trial by jury, that the issue of criminal responsibility be submitted to a separate jury. Upon a request for bifurcation, the court shall consider the substantiality of the defense of lack of responsibility and its effect upon other defenses, and the probability of a fair trial.

Section 405. Examination of Person Charged with Crime as Aid in Sentencing

Examination Before Imposition of Sentence. Whenever a person who has been criminally charged is to be sentenced, the court may defer sentence and order him to be examined for mental illness to aid it in the determination of disposition. This action may be taken on the court's initiative or on the application of the attorney for the Commonwealth, the person charged, his counsel, or any other person acting in his interest. If at the time of sentencing the person is not in detention, examination shall be on an outpatient basis unless inpatient examination for this purpose is ordered pursuant to the civil commitment provisions of Article III.

34. 50 P.S. § 7403.

Section 406. Civil Procedure for Court-ordered Involuntary Treatment Following a Determination of Incompetency, or Acquittal by Reason of Lack of Criminal Responsibility or in Conjunction with Sentencing

Upon a finding of incompetency to stand trial under section 403[35], after an acquittal by reason of lack of responsibility under section 404[36], or following an examination in aid of sentencing under section 405[37] the attorney for the Commonwealth, on his own or acting at the direction of the court, the defendant, his counsel, the county administrator, or any other interested party may petition the same court for an order directing involuntary treatment under section 304.[38]

ARTICLE V[39]

Effective Date, Applicability, Repeals and Severability

Section 501. Effective Date and Applicability

This act shall take effect 60 days after its enactment and shall thereupon apply immediately to all persons receiving voluntary treatment. As to all persons who were made subject to involuntary treatment prior to the effective date, it shall become applicable 180 days thereafter.

Section 502. Repeals

(a) The definition of "mental disability" in section 102, and sections 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 416, 418, 419, 420 and 426, act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No. 6), known as the "Mental Health and Mental Retardation Act of 1966[40]," are hereby repealed, except in so far as they relate to mental retardation or to persons who are mentally retarded.

Section 29 of the act of December 6, 1972 (P.L. 1464, No. 333), known as the "Juvenile Act[41]," except so far as it relates to

35. 50 P.S. § 7403
36. 50 P.S. § 7404
37. 50 P.S. § 7405
38. 50 P.S. § 7304
39. 50 P.S. §§ 7501 to 7503
40. 50 P.S. §§ 4102, 4401 to 4413, 4416, 4418 to 4420, 4426
41. 11 P.S. § 50-329

mental retardation or to persons who are mentally retarded, is hereby repealed.

(b) All acts and parts of acts are repealed in so far as they are inconsistent herewith.

Section 503. Severability

If any provision of this act including, but not limited to, any provision relating to children or the application thereof including but not limited to an application thereof to a child is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and to this end the provisions of this act are declared severable.

Approved the 9th day of July A.D. 1976.

Appendix B
Montgomery County Emergency Service Contact Form

☐ 302

MONTGOMERY COUNTY
MH/MR EMERGENCY SERVICE INC.
CONTACT SHEET

☐ Contact Only
☐ Evaluation Only
☐ Admission

Case #	Contact	Time	Date	Day	Intake Worker(s)	D	A	P	Other

Name (Last – First – M.I.)	Address (Complete)	Municipality & Township

Sex	Age	Birthdate	Race	Marital Status	Emp. Status	Phone #	BSU #	Living Arrangement

Caller's Name/Relationship/Agency/Phone	Van Use Information:

Major Presenting Problem:

Chronological Description of Events:

See Reverse Side ☐

Prev. Treatment/Hosp.	Pres. Treatment	Prescribed Meds

D/A Use: Types–Amounts–Frequency	Criminal Justice Info. (legal status, etc.)

Medical/Hospitalization Insurance Info.	Nearest Relative/Relationship/Phone #

Disposition:

Admission Type: 201A ☐ 201B ☐ 302A ☐ 302B ☐

Evaluating Physician: Rx: Dx:

(continued from reverse side)

MONTGOMERY COUNTY MH/MR EMERGENCY SERVICE

AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I hereby authorize payment directly to the above named hospital for the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this Admission/Evaluation. I understand I am financially responsible to the hospital for charges.

2. I hereby give my permission to the Montgomery County Emergency Service to forward to any Insurance Company to which I am a subscriber any necessary information required by the Insurance Company relative to payment of claims.

SUBSCRIBER SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE _____ DATE _____

Exemplary Projects Review Board

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EXEMPLARY PROJECT
Montgomery County Emergency Service

To help LEAA better evaluate the usefulness of this document, the reader is requested to answer and return the following questions.

1. What is your general reaction to this document?

   ☐ Excellent ☐ Average ☐ Useless
   ☐ Above Average ☐ Poor

2. To what extent do you see the document as being useful in terms of: (check one box on each line)

	Highly Useful	Of Some Use	Not Useful
Modifying existing projects	☐	☐	☐
Training personnel	☐	☐	☐
Administering ongoing projects	☐	☐	☐
Providing new or important information	☐	☐	☐
Developing or implementing new projects	☐	☐	☐

3. To what specific use, if any, have you put or do you plan to put this particular document?

   ☐ Modifying existing projects
   ☐ Training personnel
   ☐ Administering ongoing projects
   ☐ Developing or implementing new projects
   ☐ Other: _____

4. Do you feel that further training or technical assistance is needed and desired on this topic? If so, please specify needs.

5. In what ways, if any, could the document be improved: (please specify, e.g., structure/organization; content/coverage; objectivity; writing style; other)

6. How did this document come to your attention? (check one or more)

   ☐ LEAA mailing of package ☐ LEAA Newsletter
   ☐ Contact with LEAA staff ☐ National Criminal Justice Reference Service
   ☐ Your organization's library
   ☐ Other (please specify) _____

7. Have you contacted or do you plan to contact the project site for further information?

8. Check ONE item below which best describes your affiliation with law enforcement or criminal justice. If the item checked has an asterisk(*), please also check the related level, i.e.,

☐ Federal ☐ State ☐ County ☐ Local

☐ Headquarters, LEAA
☐ State Planning Agency
☐ Regional SPA Office
☐ College, University
☐ Commercial Industrial Firm
☐ Citizen Group

☐ Police*
☐ Court*
☐ Correctional Agency*
☐ Legislative Agency*
☐ Other Government Agency*
☐ Professional Associations*
☐ Crime Prevention Group*

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Your Position_____
Organization or Agency_____
Address _____

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