TESTIMONY BEFORE THE PENNSYLVANIA SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
September 30, 2015

Shelly D. Rivello, LCSW, Director
Behavioral Health Services, J.C. Blair Memorial Hospital

Chair Vance and members of the Senate Public Health and Welfare Committee, as a representative of a Hospital & Healthsystem Association of Pennsylvania (HAP) member facility, I respectfully submit this testimony regarding the mental health commitment process. I would like to thank Senator Vance, Senator Kitchen, and your fellow members of the Public Health and Welfare Committee for the opportunity to speak today. By allowing each of us here today to present information regarding the Mental Health Procedures Act—specifically the involuntary commitment process—you are engaging in dialogue where stigma is challenged, policies and practices are reviewed, and individual rights are protected.

My name is Shelly D. Rivello, LCSW, and I currently serve as the Director of Behavioral Health Services at J.C. Blair Memorial Hospital. As a small, rural hospital located in Huntingdon County, my organization strives to provide quality mental health care through inpatient psychiatric services. I am proud to be a part of this organization, as I believe we offer our community a valuable service that other small community hospitals are unable to provide in the rapidly changing field of health care. The Huntingdon County community relies on J.C. Blair Memorial Hospital - much like other rural communities in Pennsylvania rely on community hospitals to address the mental health needs of community residents.

As mental health continues to rise to a top ranking position among health indicators in our state and nation, I thank you for considering how issues of mental health impact consumers and families, facilities and organizations, and Pennsylvania communities. The Mental Health Procedures Act provides the fundamental framework for the commitment process, guiding facilities and holding us accountable for the quality of services we provide, while codifying the concept of individual rights.

I represent an organization that supports the framework offered by the commitment process as this framework helps us provide the best care we can provide within the limits of the commitment process. However, we acknowledge the limits and challenges of utilizing the involuntary commitment process within our rural community and would appreciate additional support for mental health and wellness initiatives.

As a rural facility provider and social worker, I occasionally struggle with balancing the dichotomy that exists within the involuntary commitment process for the individual. I have come to recognize that self determination does not always coincide with the need to provide emergency treatment to ensure the safety of an individual and/or the community. I struggle when individuals feel penalized from the commitment process rather than encouraged through recovery principles. And, I struggle when the system is challenged to support the individual through the involuntary commitment process beyond the initial 302 and 303 period, specifically through the 304 commitment process. As a rural facility provider, we struggle with the reality

that an individual has limited recourse for not complying with the 304 process based on system limitations to manage compliance and treatment outcomes.

Collaboration within the organization and community with medical staff, police and emergency services, mental health delegates and administrators, and many others is necessary to ensure access to the most appropriate treatment level for the individual. This is especially true within a rural community where resources are limited. Although well intended in design, the commitment process poses challenges to rural communities due in part to:

- Limited court resources;
- Limited coordination and communication among providers;
- Limited organizational resources;
- Limited access to services; and of course,
- Limited financial resources.

Budget limitations and restrictions, such as are occurring under the current budget impasse impact whether mental health providers can adequately provide services to our community. As a facility, we rely on our county funded community mental health agencies to ensure successful coordination of care to support the commitment process. Without proper funding of mental health services, there are increased risk and safety concerns associated with untimely and inadequate treatment for serious mental illness.

As a facility, we have provided services to many individuals who have demonstrated significant treatment improvements that would have been otherwise unobtainable without the involuntary commitment process. Despite an individual's initial negative feelings associated with the commitment process and emergency nature of treatment, the opportunity to protect an individual's right to treatment outweigh the risks of not receiving treatment.

Recovery and maintenance with mental illness is possible and the commitment process strives to ensure an individual has the right to treatment, even if they are unable or unwilling to recognize this potential at the time of the emergency. Once entered into treatment, facility providers, individuals, and service providers work diligently to create a treatment plan that embodies recovery, compliance, and engagement.

With limited recovery-based principles within the current language of the commitment process, individuals often feel criminalized or penalized for needing emergency medical treatment for a valid health condition. If not treated with dignity and respect throughout the commitment process, the individual may be traumatized and stigmatized. With the ultimate goal of restoration of one's functioning level, the commitment process has potential to encourage recovery and support an individual's right to treatment. The commitment process encourages treatment for those unable or unwilling to voluntarily seek services; however offers limited opportunities to amend the commitment outcome once an individual is in a stage of recovery and/or maintenance.

Much like many of you present today, the issues of access to quality mental health care and of safety resonate with me on a personal level. I am an individual with a family history of mental

illness and suicide and I proudly work and live in the small rural community with my clients. As with many of my colleagues, I have witnessed the pros and cons of the mental health commitment process and recognize that it is not a perfect system and that the opportunity for enhancement exists.

I appreciate that this committee is looking at whether an updated review of the commitment process is needed, and your willingness to consider the vast differences within the Commonwealth regarding the application of the commitment process. Identification and evaluation of trends, challenges, and service gaps is needed to engage a dialogue among stakeholders with the ultimate goal to promote an individual's right to emergency treatment and to maintain safety within our communities.

Thank you for your time and the opportunity to present my testimony today. I look forward to responding to your questions.

# # #