

Involuntary Psychiatric Evaluation and Treatment 101: Almost Everything You Should Know

Many public health polices are misunderstood most by those they are intended to help and protect. Chief among these is the law providing for “commitment” and the steps to be taken to aid someone in a psychiatric emergency. MCES has been responding to such situations since 1974. Here is an overview of the process in Montgomery County.

Roles of Montgomery County MH/MR & MCES

The Montgomery County Office of Mental Health/Mental Retardation-Drug & Alcohol Services (MH/MR) plans, funds, and administers a wide array of services to help individuals affected by mental illness. The Montgomery County mental health system strives to provide care in the community on a voluntary basis and to minimize the need for hospitalization.

There are times when an individual is involved in a serious and potentially life threatening psychiatric emergency or severe behavioral health crisis and is unwilling or unable to consent to treatment. State law empowers the County MH/MR Administrator to authorize these services without the individual’s consent. This process is also known as a civil commitment.

MCES is the sole provider of initial involuntary psychiatric evaluations and inpatient treatment in Montgomery County for individuals age 14 and over. It has provided these services on behalf of the Montgomery County MH/MR Office for almost 30 years. Such centralization and integration of functions is a key feature in the effectiveness of emergency

psychiatric services in the county and an important resource to the overall mental health system.

Involuntary intervention occurs if an individual behaving in a manner that is a “clear and present danger” to her/himself or others is observed by one or more parties willing to attest to what they have witnessed. A Mental Health Delegate determines the need for an evaluation of the individual by a physician. The Delegates are representatives of the County MH/MR Administrator who delegates this authority to them.

Involuntary intervention is always trying and traumatic. The stigma surrounding “commitment” further complicates things. A psychiatric emergency is one of the few health problems that may result in someone being helped against her or his will. Personal rights must be balanced with the obligation to protect those unable to help themselves and those who may be endangered by their actions. Consumers, family members, behavioral health providers, law enforcement, the courts, and others who may be involved with a psychiatric emergency need a basic understanding of the intervention tools available to help.

This information is for educational purposes only. Questions about involuntary evaluation and treatment should be directed to a Mental Health Delegate or an attorney. MCES is solely responsible for the accuracy of this material.



Important Numbers

Montgomery County
Mental Health Delegates
610-279-6100

Montgomery County
Mental Health Court
610-278-3791

Montgomery County
Solicitor
610-278-3033

Montgomery County
Public Defender
610-278-3295

Abington Case
Management Office (464)
215-830-8966

Lansdale Case
Management Office (463)
215-855-0780

Lower Merion Case
Management Office (466)
610-649-6512

Pottstown Case
Management Office (461)
610-326-2767

Norristown Case
Management Office (465)
610-277-4600

Telford/Souderton Case
Management Office (462)
215-257-2114

NAMI of Eastern PA
215-886-0350

Commonly Asked Questions About Involuntary Evaluation

What is the legal basis for involuntary intervention?

Government has two basic mandates: police power to protect citizens from danger and harm, and parens patriae power to help those incapable to help themselves. Under police power, government has the responsibility to protect citizens from others who may harm them. Under parens patriae power, it is the government's responsibility to act as the ultimate "parent" of all citizens and to help them in times of need. These powers underlie involuntary evaluation and treatment, and are codified in the Pennsylvania Mental Health Procedures Act.

What is the Mental Health Procedures Act?

It is the statute (Act 143, PL 817, July 9, 1976) concerning the voluntary and involuntary treatment of seriously mentally ill individuals in Pennsylvania. It applies to all psychiatric hospitalizations. It is the statutory basis for involuntary psychiatric evaluation and treatment. (It will be referred to hereafter as the "Act".) Every state has a similar law, but the specific criteria may vary.

What is a "302?"

Section 302 is the part of the Act relating to emergency evaluation and treatment without consent for observed behavior constituting a clear and present danger to the individual and/or others. The behavior must have occurred in the past 30 days. Under Section 302(a) any responsible party can petition for an involuntary evaluation by stating that an individual may be severely mentally disabled.

The need for an involuntary evaluation can only be assessed on the basis of "observed behavior." Threats, past psychiatric history, and diagnosis cannot be considered.

What conditions may result in an involuntary hospitalization?

An individual must be severely mentally disabled and pose an immediate danger to her/himself or to others. This is demonstrated by actual or attempted substantial self-injury, attempted or inflicted serious bodily harm to another person, acting in a manner that indicates that the individual may not be able to take care of her/himself without assistance. Specifically attempting suicide, showing a very high risk of suicide, or having attempted suicide may also lead to hospitalization.

What is a mental health warrant?

Reports that someone is at risk because of mental illness go to a County Mental Health Delegate. If the Delegate determines that the behavior meets the Act's criteria a warrant is issued. This authorizes a representative of the County MH/MR Administrator or the police to take someone for psychiatric examination by a physician (MD/DO) in the county where the behavior occurred and was observed. No arrest or criminal charges are involved related to the mental health warrant.

A petition does not automatically generate a warrant. The decision to issue a warrant is made by the Mental Health Delegate. Likewise a warrant does not always involve hospitalization. A physician makes the admission decision based on legal and clinical factors.

Who are the County Mental Health Delegates?

Delegates are highly experienced crisis specialists with a variety of professional behavioral health backgrounds. Most have graduate degrees in fields such as social work, psychology, and nursing. They have been trained to fairly apply the mental health law. They are very familiar with available mental health services. As circumstances permit, they try to clarify the process for all concerned. Delegates work on a full and part-time basis to assure availability. In Montgomery County, the Delegates are based in the MCEs Crisis Department.

What is the responsibility of a petitioner?

Anyone filing a petition must truthfully state in his or her own handwriting the behavior that they have personally witnessed in the past 30 days that supports the belief that an individual is a clear and present danger to her/himself or others. The petitioner will be asked to attend a hearing to testify about the information that they gave on the individual's behavior. If a petitioner does not appear the patient may be released regardless of the need for care.

Individuals in crisis may have police contact. MCES offers mental health and crisis intervention training and assistance to law enforcement, court, correctional, and probation and parole personnel. When appropriate, MCES tries to resolve such cases in a manner assuring treatment rather than incarceration. For more information see “Criminal Justice Diversion of the Mentally Ill,” the December 2002 issue of the MCES Quest. Copies are available on request.

Does filing a petition automatically result in hospitalization?

The petition may first lead to a psychiatric examination if the Delegate feels that one is needed. Hospitalization is then decided upon by an MCES psychiatrist based on the Act, the information in the petition, and an examination of the individual. About 90% of those evaluated involuntarily are found to need hospitalization.

Are petitioners sometimes uncomfortable with their role?

The process is difficult for all concerned, which is why we try to get patients to agree to a voluntary admission whenever possible. When this is not an option we remind petitioners that they are helping someone who temporarily can't help her or himself. We note that they may be keeping the person from serious harm or from harming others. Petitioners' eyewitness accounts are an essential element of the present involuntary intervention process.

Do the police or physicians need warrants?

Police officers or physicians (MDs/DOs) can take, or arrange the transport of, an at risk individual to a psychiatric facility without a warrant. This must be based on personal observation (or in the case of a physician, an assessment) that the individual may be severely mentally ill and pose an imminent danger to her/himself. This is known as a 302(b).

How long may an involuntary hospitalization last?

Section 302 provides for an involuntary admission for a period not to exceed 5 days (which in Montgomery County is spent at MCES except if illness or injury necessitates medical hospitalization). Section 303 provides for an extension of involuntary treatment (inpatient or outpatient) for up to 20 days. The extension is determined based on a hearing with the Mental Health Review Officer (see pg. 5), who can order continued care as needed.

What if the patient continues to need involuntary care?

Section 304(b) provides for extended treatment of individuals subject to a prior Section 303 ruling. Involuntary treatment (inpatient or outpatient) may be extended for up to 90 days. Section 305 provides for extensions up to 180 days.

Where is extended court-ordered treatment given?

If additional inpatient care is found to be needed it may be provided by MCEs or by another facility. The decision to transfer individuals subject to a civil commitment to other settings is based on their needs, their preferences, the availability of appropriate services, and other factors. Those moved to another care setting remain under court jurisdiction. Transfers can only be made to appropriate providers in Pennsylvania.

What is a mental health hearing?

It is an informal, civil (non-criminal) proceeding to determine if additional treatment is needed. Hearings are non-adversarial and usually brief. An attorney guides participants (both petitioners and other witnesses) on their roles. The mental health hearing assures the right to due process. The initial hearings are held at MCEs. However, they are administered by the Court of Common Pleas, which is solely responsible for scheduling and hearing times. Subsequent hearings may be held elsewhere.

What happens at a mental health hearing?

The Mental Health Review Officer (MHRO) assures that everything is done in compliance with the law and in the least restrictive setting. The MHRO presides, questions those present, reviews pertinent documentation, and decides if continuing treatment is necessary. Petitioners or others testify about the behavior that they have observed. The patient may testify and call witnesses. An attorney known as the County Mental Health Solicitor represents the petitioner(s) and MCEs. The MCEs psychiatrist reports on the individual's current status relative to the condition that led to the admission.

Do patients have legal representation at mental health hearings?

The Public Defender's Office provides representation at no cost to patients at mental health hearings. Private attorneys may also provide representation at the patient's expense. Patients may confer with their attorneys in privacy during their stay at MCEs.

May the patient waive the right to a hearing?

The patient has the right to agree to or to "stipulate" to an extension of their treatment, in which case a hearing is not necessary. Stipulation means that the patient and her/his attorney agree with MCEs that a given period of ongoing treatment is acceptable. Voluntary agreement to ongoing care does not change the individual's involuntary treatment status.

Can the Court order ongoing outpatient care?

The Act permits extended outpatient treatment. The Case Management Office monitors compliance in the area where the patient lives. If someone under an outpatient care order has an emergency a new 302 evaluation may be needed. A prior hospitalization does not mean that he/she will be immediately rehospitalized. The steps stipulated by the Act must be followed in every case. The patient's provider and the Case Management Office deal with violations of such orders, if they occur, and can answer any questions. MCEs plays no role in that process.

More on Mental Health Hearings:

- Initial Mental Health Hearings are held at MCES every Monday, Tuesday, Wednesday and Friday.
- Cases in which a patient has stipulated or agreed to treatment are heard first.
- Petitioners and witnesses may find that their testimony is unnecessary if the patient stipulates to treatment, which may occur up to the time of the hearing.
- Petitioners and witnesses may be asked to testify at later hearings to decide on extended treatment or in cases where a patient did not comply with court-ordered care.

MCES does everything it can to facilitate the participation of petitioners and witnesses in hearings. However, MCES has no control over the availability or punctuality of county court personnel or the decisions made by the Hearing Officer.

“NAMI believes that all people should have the right to make their own decisions about medical treatment. However, NAMI is aware that there are individuals with brain disorders such as schizophrenia and bipolar disorder who, at times, due to their illness, lack insight or good judgment about their need for medical treatment.”

National Alliance for the Mentally Ill

Commonly Asked Questions About Involuntary Treatment at MCES

What happens after someone is admitted to MCES?

The patient is stabilized and oriented to the hospital, MCES policies, and patient rights (see below). A physical examination is immediately done to identify any medical needs or injuries. Insofar as the patient is able, he/she participates in the planning of their care. Medications are offered when indicated. Individual and group counseling starts as soon as possible.

What rights do involuntary patients have?

Patients have rights to information, to privacy, to an attorney, to visitors at reasonable times, to telephones and mail, to appropriate personal possessions, to refuse treatment (except when doing so would lead to harm), to observe religious practices, to have special diets, to review care plans, and other entitlements. The MCES Ombudsperson, a staff member not involved in inpatient care, is available to assist patients with concerns about their care. Patients have access to an MCES grievance process, the PA Department of Welfare, and other recourse.

How long will the hospital stay last?

At MCEs the average inpatient length of stay is about 8 to 9 days. Some patients stay for a shorter period, and some stay longer depending on their needs. Our philosophy is to give care in the least restrictive setting possible. Discharge planning begins on admission and every effort is made to minimize stays consistent with patient need and safety.

How is care given at MCEs?

MCEs uses a multidisciplinary approach. The psychiatrist is the treatment team leader and prescribes medications. Psychologists provide counseling. Psychiatric nurses administer medications and assure that the patient's needs are met. Psychiatric Technicians (Psych Techs) provide support and meet day-to-day patient needs. Social Service caseworkers arrange continuing care.

MCEs was established to perform psychiatric evaluations 24/7 and to be a safe place for police to take high risk individuals to instead of jail. At MCEs a psychiatrist is on-site at all times.

Are patients helped to understand why they need care?

All MCEs patients are offered education about the nature of their disorder, short and long-term treatment options, and issues regarding ongoing risk or the possibility of recurrent crises. This is called psychoeducation and it is a very important part of effective mental health treatment. Educational sessions are given on both a group and individual basis.

What about recreational activities?

While at MCEs patients may participate in creative arts (e.g., painting or music) therapy and recreational therapy. There are also indoor and outdoor recreational activities. Patients have time for TV, videos, listening to CDs, and reading, if they wish.

What about special needs, like diet or language?

MCEs can accommodate medically restricted diets and most cultural preferences. More than a dozen languages are spoken among the staff. Forms and documents are available in Spanish. Translation and interpretative services will be arranged for on a case-by-case basis. Smoking is permitted in a designated area with outside ventilation.

Why do some patients seem better in a few days or less?

Some patients do recover quickly. Others just respond well to our highly structured setting. In most cases the symptoms are under control, but the individual still needs care for the underlying disorder. This is why the psychiatrist may recommend extending the hospital stay. Most emergency psychiatric patients need ongoing care after discharge.

Federal, state, and MCES policies guarantee patient privacy and confidentiality and prohibit identification of current or former patients or the sharing of information without their permission by MCES.

Why are readmissions sometimes necessary?

Serious mental illness, substance abuse, or other behavioral health problems are complex and persistent. Some disorders can't be cured, only managed, and there may be recurrent crises. Severe depression may return. Substance abusers may relapse before achieving recovery.

Does MCES try to prevent readmissions?

Every patient leaves with a plan for ongoing care, which is developed with their input insofar as possible. This includes guidance on maintaining insurance coverage. Patients may learn how they can identify and deal with relapse and build coping skills. The MCES Transition Specialist works with many individuals at high risk of rehospitalization to assure that they are linked to treatment and community supports.

What does MCES do to minimize admissions?

MCES tries to resolve crises in the community or, if care is indicated, in the least restrictive setting that is safe and appropriate. MCES staff deal with many problems over the phone. The MCES Mobile Crisis Service handles others on the scene. The MCES Crisis Department helps many individuals avoid admission through crisis counseling and referrals to outpatient mental health services. The Crisis Residential Program is an alternative to hospitalization.

Who pays for an emergency psychiatric hospitalization?

MCES serves patients based upon need regardless of insurance, and accepts any reimbursement that covers its services, including Medicare and Medicaid. However, the cost of hospitalization is ultimately the responsibility of the patient or the responsible family member. MCES staff assist uninsured patients in applying for coverage. Private payment arrangements are established for those able to pay.

Does MCEs provide inpatient care to prisoners?

MCEs is widely recognized for its forensic services. It offers mental health services at the Montgomery County Correctional Facility (MCCF) involving a full-time psychologist and social worker, weekly psychiatrist medication clinics, and a Transitional Case Manager who works with parolees and probationers with mental health needs who are being released. MCCF inmates needing inpatient psychiatric care may be admitted to MCEs.

More about involuntary outpatient treatment:

- The Court-designated clinic formulates a treatment plan for the patient.
- Outpatient care may include individual, group, or family therapy and/or medication.
- Patients must comply with the treatment plan and keep all appointments.
- Noncompliance for any reason may result in the hospitalization of the patient.
- The clinic may petition (Section 306) to have a noncompliant patient hospitalized.
- Section 306 is not an emergency procedure, but a “302” may be filed if there is new current applicable behavior.

One Client, Different Times, Different Behaviors, Different Outcomes

Background: Paul and Kelly, both 28, were married in April 2002, after living together for three years. They have had problems throughout their relationship. These worsened after Paul was unemployed for a few months. Things got better when he got his present job. The couple decided to buy a house. Paul used some savings to pay off Kelly’s credit cards and borrowed \$30,000 to clean up her student loans. In May, after arguments over their finances and housing choices, they separated.

June 2002: Paul and Kelly began couples’ therapy. During a session, Paul said that he was depressed and thought constantly of death and suicide. Paul was given a referral to a psychologist but did not follow-up. At the next session Paul continued to appear depressed and said that his suicidal thoughts were still present. The therapist advised Kelly to take him to MCEs. She called MCEs from their car and was told to come in.

MCEs: Paul met with a Crisis Specialist. He said that he “wanted the pain to end.” He did not specify a timeframe or means or any other plan for taking his life. Paul agreed to meet with the psychiatrist on duty. The evaluation confirmed Paul’s acute depression and a low level of suicide risk. Paul accepted a prescription for an antidepressant and agreed to contact the psychologist whom he had been referred to earlier. Even if Paul had not been cooperative, there were no grounds for involuntary hospitalization because he did not do anything to further a plan to harm himself, nor did he formulate a plan that could be carried out.

August 2002: The couple reconciled in late summer. The discord soon resumed and Paul told his parents that he was still very depressed. He told them that he had been shopping for a handgun and thinking about suicide. Paul had not refilled his prescription or seen the psychologist. His parents pleaded with him to go to MCEs, but he refused. After contacting MCEs, his father completed a petition. A Delegate decided that Paul’s behavior, as described in his father’s statement, clearly indicated that he was at risk of attempting suicide. A psychiatric evaluation was ordered and a warrant was issued.

(continued on pg. 10)

Different Outcomes (continued from pg. 9)

MCES: On learning of the warrant Paul went to MCES on his own. He told the Crisis Specialist that his thoughts about suicide had lessened while he was on medication, but were now more intense than ever. During the psychiatric evaluation he indicated the type of handgun that he would use and where he could buy it. The psychiatrist found Paul to be severely depressed and at high risk of suicide. Paul refused to be hospitalized and was involuntarily admitted to MCES as he had a plan and was in clear danger of harming himself. He received inpatient treatment for several days where he was started on medication, as well as other treatment, and no longer felt suicidal. He was discharged after his hearing. He agreed to continue the medications started during his stay and to begin outpatient counseling.

October 2002: One night, Kelly told Paul that she was seeing a former boyfriend. Later she found a receipt for a handgun and a box of cartridges. Paul said that this time he intended to end his life because his “marriage was a joke” and he was “in debt up to his neck.” He told Kelly that she’d soon be “rid of this loser” and went out. Kelly was very frightened and called 911. Soon she was giving an account of what had happened to the MCES Crisis Department. Simultaneously a call came in from Paul’s father who said that his son had locked himself in their garage and might have a gun. The local police, the MCES Mobile Crisis Team, and the MCES Ambulance soon arrived. The MCES staff contacted Paul on his cell phone. Paul acknowledged that he had a loaded revolver. Using their crisis intervention skills the MCES staff were able to keep Paul talking. Things remained tense for some time until Paul agreed to surrender the weapon to a police officer and be transported to MCES in the ambulance.

MCES: Paul was in a highly agitated state, and continued to express a desire to complete suicide even as MCES staff led him to the ambulance. Based on a police officer’s statement of the situation, a Delegate had approved an involuntary evaluation. This took place immediately upon arrival. The MCES psychiatrist found Paul to be acutely suicidal and had him admitted to the inpatient unit. After a physical examination Paul was put on a “one-to-one” suicide watch during which an MCES Psych Tech accompanied him at all times. After two days of treatment and sessions with an MCES psychiatrist, his level of suicidality abated somewhat. Paul was able to “contract for safety.” This meant that he agreed to seek out a staff member if he felt like harming himself. At his hearing, the MCES psychiatrist described Paul as seriously depressed and recommended continued hospitalization. Paul remained at MCES where he responded to treatment and was discharged after his additional stay. Given his past history, the MCES psychiatrist voiced concern that Paul might not continue with his medications and his plan for ongoing care. The Mental Health Hearing Officer placed Paul on an outpatient treatment, 90 day order with a provider in Paul’s community. Paul began individual counseling and continued on medications.

This case history reflects actual events but not the experience of an actual patient.

Misconceptions About MCES and Involuntary Care

Misconception: “My counselor says that he can put me into MCES if I don’t cooperate”

Correction: Any adult may initiate a petition, but authorization of an evaluation is made only by a Mental Health Delegate, and only an MCES psychiatrist makes the decision about admission.

Misconception: “Is it true that any police officer can take you to MCES if they want to?”

Correction: The police are empowered to bring those who may need help to a hospital. MCES offers training, education, and on-site help to police to identify cases when our care may be needed. The psychiatrist, however makes the admission decision.

Misconception: “A lot of people that go to MCES end up in a state hospital, don’t they?”

Correction: About 1% or less of those discharged from MCES go on to a facility such as Norristown State Hospital (NSH). This happens only if they clearly need long-term care and if a bed is available at NSH.

Misconception: “MCES just does commitments and helps people who don’t want it”

Correction: Involuntary interventions are only part of our mission. We help people who call or come to our crisis center and those who request admission to our hospital or Crisis Residential Program. Sixty percent of our admissions are voluntary.



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Proposed Amendments to the Mental Health Procedures Act

The act was last amended in 1996 with the passage of Act 77, which requires that notification be given to the Pennsylvania State Police when an individual is involuntarily hospitalized under Section 302. This information becomes part of the database that is checked by firearm dealers prior to selling a gun.

Amendments to the Act are proposed in the Pennsylvania House or Senate during almost every legislative session. These may originate with individual legislators acting on their own or on behalf of constituent, organizations, lobbyists, interest groups, or other parties. Even when not enacted these bills indicate areas of concern about the present Act.

One example was HB 2374 introduced in the 2002 legislative session. This bill would have significantly broadened the criteria for involuntary evaluation and treatment to include, among other things, cruelty to an animal and significant damage to “substantial property.” HB 2374 would have also permitted consideration of diagnosis, treatment history, and past behavior. Public hearings were held on this bill, but no further action was taken.

During the present 2003 session, SB 499 was introduced. It would create a state/county structure to administer comprehensive involuntary outpatient treatment for adults suffering from serious mental illness who do not comply with their treatment plan. This bill is based on “Kendra’s Law,” the New York state law passed shortly after a noncompliant mentally ill individual pushed a young woman into the path of a subway train.

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