IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

J.H., by and through his next friend, Flo Messier; L.C., by and through her next friend, Flo Messier; R.J.A., by and through his next friend, J.A.; Jane Doe, by and through her next friend, Julia Dekovich; S.S., by and through his next friend, Marion Damick; G.C., by and through his next friend, Luna Pattela; R.M., by and through his next friend, Flo Messier; P.S., by and through his next friend, M.A.S.; T.S., by and through his next friend, Emily McNally; M.S., by and through his next friend, Emily McNally; and all others similarly situated, **Plaintiffs** **v.** **Teresa D. Miller in her official capacity as Secretary of the Pennsylvania Department of Human Services; Jessica Keith in her official capacity as the Chief Executive Officer of Norristown State Hospital; Stacey Keilman in her official capacity as the Acting Chief Executive Officer of Torrance State Hospital,** **Defendants**	**Civil Action No. 1:15-cv-02057-SHR** **Judge Sylvia H. Rambo**

BRIEF IN OPPOSITION TO PLAINTIFFS' SECOND RENEWED AND AMENDED MOTION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

INTRODUCTION

From the outset of this litigation, the Department of Human Services ("Department") has shown its commitment, with demonstrable results, to constitutional wait times for individuals declared incompetent to stand trial on criminal charges and who need competency restoration treatment. Since January 2016, when this Court approved the First Settlement Agreement that the parties negotiated, the Department has infused unprecedented financial and other resources into the forensic system in Pennsylvania. The Department has opened 100 new inpatient and 75 new institutional "step-down" beds. It has invested close to $64 million to develop 463 new community treatment and supported housing slots, more than 370 of which are in operation, with the remainder under active development.

The actions that the Department has taken to transform the forensic system have resulted in dramatic reductions in the wait lists since this lawsuit was filed. In November 2015, more than 200 persons were waiting to be admitted to Norristown State Hospital ("NSH") or Torrance State Hospital ("TSH"), and the average wait time for NSH was 114 days and for TSH was 30 days from the date the hospitals received the full referral. As of March 29, 2018, 56 persons were waiting to be admitted to NSH an average of 44 days from the date of the court commitment order, and 24 individuals were waiting for admission to TSH an

average of 29.5 days from the date of the court order. From January 2016 to March 29, 2019, the hospitals admitted 1,116 patients to the forensic units and discharged 1,058 patients from the forensic units. An additional 911 persons were removed from the wait lists before being admitted to the forensic units, after it was determined that they did not need an inpatient level of care.

From the outset of this litigation, the parties have agreed that the delays in admission to state hospitals for competency restoration treatment are unacceptable. Recognizing that the forensic system needed a major overhaul, the parties have entered into two settlement agreements and were in the process of negotiating a third when Plaintiffs renewed their request for preliminary injunctive relief.[1] Notwithstanding the commitment reflected in the Department's extensive actions and the results of those actions, Plaintiffs have chosen to disregard the systemic issues identified by their independent consultant and ask this Court to impose a remedy that will not resolve those systemic issues.

The Department agrees that more work is needed to reduce the wait times to constitutionally acceptable levels. Plaintiffs' requested relief is not, however, required by the Constitution and ignores the practicable impediments that would make the requested remedy impossible to achieve. Their motion should be denied.

[1] The parties have continued their negotiations since Plaintiffs filed their motion and remain hopeful that they will reach agreement to resolve the motion.

COUNTER-STATEMENT OF THE CASE[2]

The Forensic Mental Health System in Pennsylvania

Admission to a state psychiatric hospital begins with a court order committing an individual for competency restoration treatment. The county courts of common pleas have the authority to declare an individual incompetent to stand trial, commit the individual to the Department for restoration treatment, and order transfer of the individual to and from the state hospitals. Some counties utilize their own evaluators to conduct a court-ordered competency evaluation, whereas others utilize the Department's contracted evaluators. When the evaluation is completed with a clinical finding of incompetent to stand trial, the court issues an order declaring that the individual is incompetent to stand trial and a subsequent order for competency restoration services.

After the commitment order is issued, the process to transfer the individual to the state's forensic units at NSH and TSH begins. Multiple documents are needed before someone can be admitted to the hospitals: 1) court order; 2) completed referral form; 3) affidavit of probable cause, criminal complaint, or arrest record; 4) all prior evaluations; 5) assessment screens; 6) medication administration record; 7) progress notes; and 8) current treatment plan. See

[2] The facts in the Introduction and in the Counter-Statement of the Case are supported by the Declaration of Philip E. Mader, attached hereto as Exhibit "A."

Bulletin OMHSAS-16-10, attached hereto as Exhibit "B," Attachment 5. Each of these documents is necessary for the Department to provide a safe and therapeutic environment for both the individual and staff.

After the hospital receives all the information, it contacts the county to schedule transfer of the individual to the designated forensic unit. The respective county's sheriff transports the individual to the designated facility.

After the Department's clinicians determine that a person is clinically ready for disposition, either because he or she has regained competency, or because he or she is unlikely to regain competency, the hospital formally notifies the county court. Depending on the response to the clinician's report, the court may re-commit the individual for additional restoration services, may issue an order to transfer the individual back for disposition of the criminal charges, or may order transfer or discharge to an alternate setting. If the person is to return to the county jail, the county's sheriff is responsible for transporting the individual.

The Department's Actions to Transform the Forensic System

Since the First Settlement Agreement, the Department continues to engage the system statewide and has materially complied with its agreements with Plaintiffs. In accordance with the First Settlement Agreement, NSH and TSH assessed individuals on the wait lists, and in the forensic and civil units. These assessments addressed the clinical and legal obstacles for each individual. The

Department also funded 120 new community treatment slots to be created in the counties to expand treatment opportunities and provided funding for 100 supported housing slots in Philadelphia to assist individuals to move through the continuum of care.

Although the First Settlement Agreement required the Department to fund 120 new community slots plus the 100 supported housing slots, the Department continued to fund and work on adding community treatment slots into the system. The Department continued to receive and approve county proposals for the creation of slots, beyond those required by the First Settlement Agreement. The Department also collaborated with Plaintiffs' expert, Joel Dvoskin, and created an action plan that outlined steps to reduce the wait list and wait times.

In addition to completing assessments and funding new community treatment slots, the Department made operational changes and engaged the forensic system on a local level. The Department revised its bulletin, OMHSAS-16-10, updating the procedures pertaining to referrals, admissions, transfers, and level of care. See Exhibit "B." The bulletin clarified the information to be provided for each individual referred to the forensic units and specified the information needed for an expedited commitment. The Department also established county review teams in both Allegheny and Philadelphia counties. These teams consist of members from the county prosecutor's office, public defender, county mental

health administrators, and staff from NSH or TSH. The teams meet to discuss the status of the individuals in the forensic units, as well as individuals on the wait lists. The goal is to identify individuals who can be diverted from admission to or be discharged from the forensic units at NSH or TSH. The Department meets with county judges to discuss other placement options for those individuals who could be served in less restrictive settings.

Despite the extensive actions undertaken by the Department during 2016-2017, the wait lists and the wait times remained high. Specifically, the wait list grew from 206 people awaiting treatment on January 29, 2016, to 256 individuals awaiting treatment on May 26, 2017, and the average wait times for persons on the wait lists were 145 days at NSH and 50 days at TSH, for a combined average wait time of 142 days.

Because of the lack of progress in reducing the wait lists and wait times despite the Department's unprecedented investment of financial and personnel resources, Plaintiffs filed a renewed and amended motion for preliminary injunction on May 11, 2017. See ECF 40. Soon thereafter, Plaintiffs and the Department entered into a Second Settlement Agreement, which this Court approved. See ECF 59. Once again, the Department agreed to take actions that the parties believed would reduce wait times to constitutional levels. Id.

The Department has created three step-down units with a total of 75 beds on the NSH campus, which added a less-restrictive treatment setting to prepare patients for an eventual move into the community. The first step-down unit with 25 beds opened in September 2016, and the second unit with an additional 25 beds opened in February 2017. The remaining step-down beds were converted from civil beds as those beds became available. The Department continues to convert civil beds to this use as beds become unoccupied and available.

Prior to entering into the Second Settlement Agreement, the Department engaged in a Six Sigma process to identify inefficiencies within the system, and streamline the process for commitments, diversions, and discharges at NSH. The outcomes, while statewide, focused on Philadelphia in light of the monthly number of commitments referred from that county. Philadelphia and Delaware counties participated and provided input in how system functionality could be improved, such as template language for court orders that all counties would use.

Even though the Department completed the Six Sigma process, the Department agreed to engage an independent consultant, Public Research Associates ("PRA"), recommended by Plaintiffs. The Department welcomed input from the independent consultant, since the criteria it would analyze extended beyond Defendants' locus of control. PRA ultimately identified eleven Recommendations. See Exhibit "A" to Brief in Support of Plaintiffs' Second

Renewed and Amended Motion for Preliminary Injunction ("PRA Report"). Only one of those recommendations identified a requirement that the Department create more institutional forensic beds, which the Department had already planned to do at the time PRA issued its report. Id. at 13.

The remaining PRA Recommendations identified issues within the system at the local level. PRA proposed to address several issues within the forensic system ranging from creation of community-based outpatient competency restoration programs, to reviews of individuals in treatment at NSH or TSH for one year, to creation of community treatment opportunities for individuals unlikely to regain competency. Id. at 4, 7. The Department accepted each of the Recommendations.

The Department's actions began to produce positive results: both the number of individuals on the wait lists and the combined wait times for individuals on the wait lists decreased. Specifically, on June 1, 2018, 183 individuals were waiting for admission to the hospitals an average of 94 days. Of those 183 individuals, 129 individuals were waiting for admission to NSH for an average of 105 days and 54 individuals were waiting for admission to TSH for an average of 67 days.

In March 2018, Plaintiffs acknowledged the positive developments but expressed concern that the progress may not continue. See Email from Witold Walczak, Exhibit "C" to Brief in Support of Plaintiffs' Second Renewed and Amended Motion for Preliminary Injunction. Counsel requested additional

commitments from the Department to reduce wait times. Id. In response, the parties engaged in discussions to develop additional commitments from the Department to reduce wait times to a constitutional level. The Department committed to take the following actions:

- By March 31, 2019, make available resources to fund and operationalize at least 125 new treatment slots for class members in addition to those originally specified in the First Agreement and Second Agreement;
- By March 31, 2019, reduce the number of class members on the joint NSH and TSH wait lists to fewer than 90 individuals;
- By March 31, 2019, reduce wait times to no longer than 90 days for any class member on the wait list for NSH, and no longer than 60 days for any class member on the wait list for TSH; and
- By September 30, 2019, reduce wait times for every class member on the wait lists to no longer than 21 days.

Over the last few months, the Department has achieved significant and consistent reductions in the number of individuals on the wait lists and the wait times those individuals are experiencing. Specifically, from June 1, 2018, to March 29, 2019, the number of individuals on the wait list decreased from 183 to 76, and the average number of days that individuals were on the wait list from the date of court order was 44 days for NSH and 29.5 days for TSH, for a combined average wait time of 39.7 days. The average wait times from the date the hospitals received the county referrals to the admission date was 30 days for NSH and 14.5 days for TSH, for a combined average wait time of close to 25 days. The

Department remains committed to reduce wait times for every individual on the wait list to 21 days by September 30, 2019, and is undertaking actions that are commensurate with that commitment.

ARGUMENT

PLAINTIFFS HAVE NOT MET THE HEIGHTENED BURDEN NECESSARY TO PREVAIL ON THEIR MOTION.

A preliminary injunction is an extraordinary remedy, which should not be granted lightly. See, e.g., Am. Freedom Defense Initiative v. Southeastern Pa. Transp. Auth., 92 F. Supp. 3d 314, 322 (E.D. Pa. 2015) (citing Instant Air Freight Co. v. C.F. Air Freight, Inc., 882 F.2d 797, 800 (3d Cir. 1989)). A preliminary injunction should be granted only when it can be restricted to specific, limited circumstances. Am. Freedom Defense Initiative, 92 F. Supp. 3d at 322 (citing AT&T v. Winback Conserve Program, Inc., 42 F.3d 1421, 1427 (3d Cir. 1994)).

To succeed on their claim for injunctive relief, Plaintiffs must demonstrate that they have a reasonable probability of success on the merits of their claim; that they will suffer irreparable harm if the court denies their motion; that no other party will suffer serious harm if the court issues the injunction; and that preliminary relief will serve the public interest. See, e.g., Brian B. v. Dep't of Educ., 230 F.3d 582, 585 (3d Cir. 2000); Gerardi v. Pelullo, 16 F.3d 1363, 1373 (3d Cir. 1994); S.I. Handling Sys., Inc. v. Heisley, 753 F.2d 1244, 1254 (3d Cir. 1985).

Plaintiffs carry an even heavier burden here because they request relief that extends beyond merely preserving the status quo. Instead, Plaintiffs request this Court to order relief that requires admission to the forensic units of NSH and TSH within seven days of the court committing the individual to the hospital. "[W]hen mandatory injunctive relief is sought, 'the burden on the moving party is particularly heavy.'" Trinity Indus., Inc. v. Chicago Bridge & Iron Co., 735 F.3d 131, 139 (3d Cir. 2013) (quoting Punnett v. Carter, 621 F.2d 578, 582 (3d Cir. 1980)). "Indeed, the moving party's 'right to relief must be indisputably clear.'" Id. (quoting Communist Party v. Whitcomb, 409 U.S. 1235, 1235 (1972)). Mandatory injunctive relief is an extraordinary remedy that is granted only sparingly by the courts. Id. (citing Communist Party, 409 U.S. at 1235). Courts should weigh the possible harm to other interested parties when reviewing a plaintiff's request for mandatory relief. Punnett, 621 F.2d at 587–88. The moving party's "right to relief must be indisputably clear" to grant the mandatory relief. Trinity Indus., 735 F.3d at 139 (citing Communist Party, 409 U.S. at 1235).

A. Plaintiffs Have Not Satisfied All Four Criteria Necessary for a Preliminary Injunction.

Before a court issues a preliminary injunction for mandatory relief, it is particularly appropriate to consider the possible harm to the other parties, not just the moving party. See Punnett, 621 F.2d at 587-88. The Department will be subject to harm, and preliminary relief will not serve the public interest because the

issuance of a preliminary injunction with Plaintiffs' requested relief will subject the Department to sanctions for actions or inactions that are outside its control.

When the First Settlement Agreement did not alleviate the forensic wait list issues, the Department accepted Plaintiffs' recommendation to engage PRA to conduct a system-wide evaluation of the forensic mental health system and issue a report. See ECF No. 59 at ¶ 1. The PRA Report identified county-level barriers outside the Department's control that significantly contribute to the forensic wait list issues. See PRA Report at 13. The PRA Report identified that out of a sample size of 97 individuals on the wait lists, 32% were competent to stand trial, 32% appeared incompetent to stand trial but could safely function in the community, and the final 36% required hospital-level care. Id. at 6. Accordingly, 64% of the individuals in the sample did not need to be on the wait lists. In connection with this finding, PRA also observed a lack of county-based options. Id. at 7–8.

PRA also noted that one-quarter of the beds then in use at NSH were occupied by individuals that hospital clinicians determined were competent. Id. at 4. After the hospitals notify the specific county that an individual is competent to stand trial, the county plans and provides the transportation back to the jail. Although the hospitals and the county at times disagree about the competency of the individual, sometimes there is simply a delay in returning individual to jail for disposition of the criminal charges. Id. at 4. This adds time to the length of stay

and stymies efforts to admit individuals awaiting treatment. Id. at 4. PRA's analysis demonstrates that issues with discharging patients back to their counties is a dilemma outside of the Department's control. Id. at 13.

PRA's identification of systemic issues illustrates that only one-third of individuals on the wait lists at the time required inpatient treatment, with one-quarter of the population in the forensic units competent to stand trial but not returned for disposition of their charges. Id. at 4. In light of these circumstances, a preliminary injunction would result in undue harm to the Department because it would subject the Department to sanctions for actions and inactions that even Plaintiffs' recommended expert acknowledged are county level-issues not within the Department's control.

B. Plaintiffs' Requested Relief Is Not Equitable.

Plaintiffs request that this Court grant a preliminary injunction and order the Department to transfer all class members to a non-punitive, mental health setting for restoration treatment within seven days of the common pleas court's commitment order. See Brief in Support of Plaintiffs' Second Renewed and Amended Motion for Preliminary Injunction at 18. The requested relief is not equitable, realistic, or reasonable due to practical impediments and delays for good cause outside the Department's control. When seeking a preliminary injunction,

one of the requirements that a plaintiff must establish is that the balance of equities tips in his favor. Winter v. Natural Res. Defense Council, 555 U.S. 7, 20 (2008).

To support their demand that seven days is the only constitutionally acceptable maximum amount of time that class members should wait for admission to the state hospitals, Plaintiffs rely on only two cases that established the seven-day requirement. Plaintiffs point to the decision in Trueblood v. Wash. State Dep't of Soc. & Health Servs., 101 F. Supp. 3d 1010 (W.D. Wash. 2015), to support their position, but the Ninth Circuit recognized that issues outside Washington's control can legitimately create delays. Trueblood v. Wash. State Dep't of Soc. & Health Servs., 822 F.3d 1037, 1045 (9th Cir. 2016) ("practical impediments, such as intervening weekends or the time necessary to obtain documents, can eat up the time period" for evaluations within seven days). The Ninth Circuit vacated the district court's decision to require evaluations within seven days and remanded the matter back for consideration of the practical impediments that were outside the state's control. On remand, the district court recognized, among other things, delays in receiving all required documentation, delays caused by waiting for intoxicants to clear an individual's system, and delays caused by an evaluator's

need for additional records. Trueblood v. Wash. Dep't of Soc. & Health Servs., No. C14-1178-MJP, 2016 WL 4268933 (W.D. Wash. Aug. 15, 2016).[3]

Although the Ninth Circuit and the district court in Trueblood were addressing the practical impediments to conducting competency evaluations within seven days, the same rationale and reasons apply to the reasonable delays for admission to NSH and TSH. In fact, the impediments to the admission of patients to the hospitals are more substantial than impediments to evaluations because the admission of patients entails taking physical custody of patients and ensuring their physical and mental well-being.

Specifically, the individuals ordered to NSH and TSH are in the physical custody of the counties. Exhibit "A" at ¶ 57. Thus, the county must provide the hospital with a referral packet that includes the medical clearance to admit the individual for treatment. Id. at ¶¶ 11, 58. NSH and TSH also need a valid court order to accept custody, as well as a completed referral packet. Id. at ¶ 11. The referral packet contains all of the documentation necessary for the hospital to treat an individual as well as assess any danger that staff should be aware of when

[3] Prior to the Ninth Circuit's decision, the district court had modified the initial permanent injunction to allow for a good cause exception to the timeframe for admission of class members ordered to receive competency services in state hospitals. Trueblood, 2015 WL 13664033 at *2 (W.D. Wa. May 6, 2015). The good cause exception allowed for delays in admission when the medical condition of the individual did not allow for transport to the facility until the individual was medically cleared. Id.

caring for the individual. Id. at ¶¶ 12-13. NSH and TSH staff need to know that an individual is medically cleared to come for restoration treatment. Id. at ¶¶ 13, 58. Many times, NSH and TSH experience a delay in the receipt of pertinent information, which delays the admission. Id. at ¶ 59.

Delays are also associated with discharging patients determined competent to stand trial. At times, the hospital and a county disagree about the competency of an individual, which requires discussion and some additional collaboration. Id. at ¶ 60. Other times, counties are delayed in transporting individuals from the forensic units back to jail after an individual has been assessed to be competent to stand trial. Id. at ¶ 63. Such a delay adds time to the patient's length of stay in the hospital, impeding efforts to make beds available for individuals awaiting treatment. Id. at ¶ 64. These types of issues create delays in admitting individuals to the forensic units similar to the delays recognized by the district court in Trueblood.

Plaintiffs also rely on Or. Advocacy Ctr. v. Mink, 322 F.3d 1101 (9th Cir. 2003), as the other case that established a seven-day admission requirement. That case is distinguishable, however, because the Ninth Circuit there noted that the "district court set the time limit at seven days based in part on the Oregon legislature's choice of that time limit in a now-superseded version of the relevant state statute." Id. at n.13. The Court's observation underscores why Plaintiffs'

overstate their reliance on these two cases to persuade this Court to hold that seven days is the maximum allowable wait time that is constitutionally acceptable.

Seven days is by no means the litmus test for maximum allowable wait times across the nation. The District Court for the Eastern District of Louisiana established a 21-day timeframe for transferring individuals into competency restoration settings. See Advocacy Ctr. for the Elderly & Disabled v. La. Dep't of Health & Hosps., 731 F. Supp. 2d 603, 627 (E.D. La. 2010). This variance illustrates that maximum allowable wait times may be based on consideration of the specific circumstances each state faces in providing competency restoration.

A wait of 21 days for restoration treatment in Pennsylvania's state hospitals comports with constitutional requirements because practical impediments outside of the Department's control account for at least a portion of the time an individual waits to be admitted. Accordingly, the seven-day timeframe demanded by Plaintiffs is not equitable.

CONCLUSION

For the reasons set forth above, the Defendants request that this Court deny Plaintiffs' requested preliminary injunctive relief that class members be admitted to the state hospital forensic units within seven days of the court commitment.

Respectfully Submitted,

Dated: April 23, 2019

/s/ Doris M. Leisch
Doris M. Leisch
Chief Counsel
Attorney I.D. No. 42375

Matthew J. McLees
Chief of Litigation
Attorney I.D. No. 71592

Marisa L. Cohan
Senior Counsel
Attorney I.D. No. 200986

Department of Human Services
Office of General Counsel
3rd Floor West
Health & Welfare Building
Harrisburg, PA 17120
(717) 783-2800

LOCAL RULE 7.8(b)(2) CERTIFICATION

I certify under penalty of perjury that the Brief in Opposition to Plaintiffs' Second Renewed and Amended Motion for Preliminary Injunction complies with Local Rule 7.8(b)(2) because, based on the word processing system used to prepare the Brief, Word 2016, the Brief contains 4,058 words (excluding the Table of Contents and Table of Authorities).

Date: April 23, 2019

/s/ *Matthew J. McLees*
Matthew J. McLees

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

J.H., by and through his next friend, Flo Messier; L.C., et al., **Plaintiffs** **v.** **Teresa D. Miller in her official capacity as Secretary of the Pennsylvania Department of Human Services, et al.,** **Defendant**	**Civil Action No. 1:15-cv-02057-SHR** **Judge Sylvia H. Rambo**

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have on this 23rd day of April, 2019, served a copy of the foregoing Brief in Opposition to Plaintiffs' Second Renewed and Amended Motion for Preliminary Injunction, via electronic mail, on Plaintiffs' counsel:

David P. Gersch, Esq.
Arnold & Porter LLP
601 Massachusetts Ave., N.W.
Washington, D.C. 20001
David.Gersch@aporter.com

Witold J. Walczak, Legal Director
ACLU of Pennsylvania
247 Fort Pitt Blvd.
Pittsburgh, PA 15222
VWalczak@aclupa.org

/s/ Matthew J. McLees
Matthew J. McLees
Chief of Litigation
Attorney I.D. No. 71592
Department of Human Services
Office of General Counsel
Health & Welfare Building
Harrisburg, PA 17120
(717)783-2800

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

J.H., by and through his next friend, Flo Messier; L.C., by and through her next friend, Flo Messier; R.J.A., by and through his next friend, J.A.; Jane Doe, by and through her next friend, Julia Dekovich; S.S., by and through his next friend, Marion Damick; G.C., by and through his next friend, Luna Pattela; R.M., by and through his next friend, Flo Messier; P.S., by and through his next friend, M.A.S.; T.S., by and through his next friend, Emily McNally; M.S., by and through his next friend, Emily McNally; and all others similarly situated, **Plaintiffs** **v.** **Teresa D. Miller in her official capacity as Secretary of the Pennsylvania Department of Human Services; Jessica Keith in her official capacity as the Chief Executive Officer of Norristown State Hospital; Stacey Keilman in her official capacity as the Acting Chief Executive Officer of Torrance State Hospital,** **Defendants**	**Civil Action No. 1:15-cv-02057-SHR** **Judge Sylvia H. Rambo**

DECLARATION OF PHILIP E. MADER

I, Philip E. Mader, hereby aver as follows:

1. I am the Director of the Bureau of Community and Hospital Operations in the Office of Mental Health and Substance Abuse Services ("OMHSAS") of the Pennsylvania Department of Human Services ("Department").

2. My responsibilities include oversight of compliance with all applicable federal and state laws, regulations, policies, and any other operational guidelines pertaining to hospitals serving the mental health and substance use disorder community, which includes the Department's state hospital system.

3. I have held this position since the outset of this litigation.

State Hospitals

4. OMHSAS is the program office within the Department that is responsible for the operation and oversight of the state hospital system, including Norristown State Hospital ("NSH") and Torrance State Hospital ("TSH").

5. NSH and TSH are psychiatric facilities that provide mental health treatment along with treatment for substance use disorders.

6. The county courts of common pleas have the authority to order a psychiatric evaluation, declare an individual incompetent to stand trial, commit the individual to a state hospital for restoration treatment, and order transfer of the individual to and from the Department's facilities.

7. Within NSH and TSH, OMHSAS operates two forensic units. Most individuals residing in forensic units have been declared incompetent by the courts to stand trial on criminal charges. A few individuals in the forensic units were found not guilty by reason of insanity.

8. Some counties utilize their own evaluators to conduct a court-ordered competency evaluation, whereas others utilize the Department's contracted evaluators.

9. Once the evaluation is completed with a clinical finding of incompetent to stand trial, the court issues a determination that the individual is incompetent to stand trial and a subsequent order for competency restoration services.

10. A total of 337 beds at NSH and TSH are dedicated to forensic patients.

11. To admit someone to and treat someone at NSH and TSH, the hospitals need to receive a referral packet from the county from which the individual has been committed.

12. The Regional Forensic Psychiatric Center Preadmission Referral packet ("referral packet") consists of: 1) court order; 2) completed referral form; 3) affidavit of probable cause, criminal complaint, or arrest record; 4) all prior evaluations; 5) assessment screens; 6) medication administration record; 7) progress notes; and 8) current treatment plan.

13. Each of these documents is necessary for the hospitals to provide a safe and therapeutic environment for both the individual and staff.

14. When the hospital receives all of the information, it contacts the county to schedule transfer of the individual to the designated forensic unit. The respective county's sheriff transports the individual to the designated facility.

15. Both NSH and TSH have a waitlist for forensic services.

16. Shortly after the commencement of this litigation, 211 individuals were waiting for admission to a forensic unit for an average wait time of 99 days from the date of referral to November 5, 2015.

17. As of March 29, 2019, 76 individuals were on the wait list, with 52 individuals waiting for NSH admission and 24 waiting for TSH admission.

18. As of March 29, 2019, the 52 individuals waiting for admission to NSH were waiting an average wait time of 44 days from the date of the court commitment orders.

19. If the average wait time is calculated from the date the hospital received the referral packet, the average wait time for the 52 individuals waiting for admission to NSH was 29.6 days.

20. As of March 29, 2019, the 24 individuals waiting for admission to TSH were waiting an average wait time of 29.5 days from the date of their court orders.

21. If the average wait time is calculated from the date the hospital received the referral packet, the average wait time for the 24 individuals waiting for admission to TSH was 14.5 days.

22. From January 2016, when the Court approved the First Settlement Agreement, to March 29, 2019, the Department has admitted 1,116 patients to the forensic units and has discharged 1,058 patients from the forensic units.

23. Not all of the individuals who have been on the wait lists were admitted to the forensic units.

24. The Department is aware of 911 individuals who were removed from the wait list before admission since December 2, 2015, for various reasons, including becoming competent and no longer needing restoration treatment.

25. As agreed to in the First Settlement Agreement, the Department provided funding to counties to develop 120 community treatment slots in addition to the $1 million it had already committed to create 100 supported housing opportunities in Philadelphia to assist individuals moving through the continuum of care.

26. Even after it met its funding commitment under the First Settlement Agreement, the Department continued to work with the counties to fund and work on adding more community beds to the system.

27. The OMHSAS also began working with Plaintiffs' expert, Joel Dvoskin.

28. The Department created an action plan that contained the steps it would take to reach the outlined goals.

29. The OMHSAS made operational changes and engaged the forensic system at the local level.

30. The Department revised its bulletin, OMHSAS-16-10, updating its procedures pertaining to referrals, admissions, transfers, and level of care.

31. The OMHSAS also established county review teams in Allegheny and Philadelphia counties.

32. The teams consist of members from the county prosecutor's office, public defender, county mental health administrators, and staff from NSH and TSH.

33. The teams meet to discuss the status of individuals in the forensic units and on the wait lists with the goal of identifying individuals who can be discharged from the hospitals or who can be diverted from admission to the forensic units at NSH and TSH.

34. The Department engaged in a Six Sigma process to identify inefficiencies in the forensic system, and streamline the process for commitments, diversions, and discharges at NSH.

35. Despite the extensive actions taken by the Department, the wait lists and wait times remained high.

36. The wait lists grew from 206 individuals awaiting treatment on January 29, 2016, to 256 individuals awaiting treatment on May 26, 2017, and the average wait times for those on the wait lists were 145 days at NSH and 50 days at TSH, for a combined average wait time of 142 days.

37. Those wait time averages were calculated using the time individuals on the wait list were waiting from the date the hospitals received the referral packet to May 26, 2017.

38. During this time, the Department was tracking and calculating wait times only from the date the referral packets were received.

39. Because the wait lists remained high, the parties entered into a Second Settlement Agreement under which the Department agreed to undertake additional initiatives.

40. The Department provided funding to counties to develop 29 community treatment slots in addition to the 120 funded under the First Settlement Agreement.

41. As of March 27, 2019, the Department also opened three units containing at total of 75 step-down beds.

42. The step-down units added a less-restrictive treatment setting to prepare patients for eventual discharge into the community.

43. The first unit with 25 beds opened in September 2016 and the second unit with an additional 25 beds opened in February 2017.

44. The remaining step-down beds were converted from civil beds as those beds became available.

45. The Department accepted the Plaintiffs recommendation to engage an independent consultant, Policy Research Associates ("PRA"), to conduct a system-wide evaluation of the forensic mental health system and issue a report.

46. In its report, PRA identified eleven recommendations and identified county-level barriers that are not within the Department's control but significantly contribute to the forensic wait lists.

47. The Department has implemented each of the recommendations directed at the state level.

48. After taking these steps, the Department began to see progress in reducing the wait lists.

49. On June 1, 2018, 183 individuals were on the wait lists with an average wait time of 94 days, the wait times still being tracked and calculated based on the date the hospitals received the full referral packet.

50. Of those 183 individuals, 129 individuals were waiting for admission to NSH with an average wait time of 105 days and 54 individuals were waiting for admission to TSH with an average wait time of 67 days.

51. The Department continues to receive proposals and fund new community treatment slots within various counties.

52. Since the outset of this litigation, the Department has invested $63,748,500 in developing community treatment opportunities for individuals that had been incompetent to stand trial.

53. The Department has increased the number of forensic beds at NSH and TSH from 237 to 337 forensic beds.

54. In addition to the treatment slots created in accordance with the First and Second Settlement Agreements, the Department has funded 214 community treatment slots, with 92 of these additional community beds currently open and 122 still in development.

55. After these additional slots are developed, a total of 463 new community and supportive housing slots will have been added for community treatment of individuals leaving the forensic units or the wait list since the beginning of this litigation.

56. Practical impediments out of the Department's control add time to an individual's wait for treatment.

57. The individuals committed by court order to NSH and TSH are in the physical custody of the counties.

58. The counties must provide NSH and TSH with the necessary paperwork and medical clearance to allow the hospitals to commit the individual for treatment.

59. NSH and TSH experience a delay in the receipt of pertinent information which delays admission.

60. At times, there is a disagreement with a county about the competency of an individual which requires discussion and some additional collaboration.

61. The counties also are responsible for transporting the individuals to and from the forensic units.

62. These types of issues create delays in the admissions of individuals to the forensic units.

63. At times, counties are delayed in transporting individuals from the forensic units back to jail after an individual has been assessed as competent to stand trial.

64. Such delay adds time to the length of stay a patient, impeding efforts to make beds available for individuals awaiting treatment.

I declare, under penalty of perjury, pursuant to 18 Pa. C.S. § 4904(a), that the foregoing averments are true and correct, to the best of my knowledge, information, and belief.

Date: 4/23/19

Philip E. Mader, Director
Bureau of Community and Hospital Operations
Office of Mental Health and Substance Abuse Services
Department of Human Services

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

ISSUE DATE	EFFECTIVE DATE:	NUMBER:
July 14, 2016	Immediately	OMHSAS-16-10

SUBJECT: Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers

BY:

Dennis Marion
Deputy Secretary
Office of Mental Health and Substance Abuse Services

SCOPE:

County Commissioners
County MH/ID Administrators/BSU Directors
Behavioral Health Managed Care Organizations
Regional Mental Health Community Program Managers
Chief Executive Officers, State Hospitals
Chief Forensic Executives, Regional Forensic Psychiatric Centers
Forensic Liaisons
Superintendent, State Correctional Facility at Muncy
County Jail Wardens
Public Defenders
District Attorneys
Mental Health Review Officers
Courts of Common Pleas Judges
Magisterial Judges

PURPOSE:

This Bulletin implements the protocol and operational changes approved by the Secretary of the Department of Human Services (DHS) for the operation of Regional Forensic Psychiatric Centers (RFPCs). The changes addressed by this policy include the establishment of a centralized referral process to the RFPCs.

BACKGROUND:

The Office of Mental Health and Substance Abuse Services (OMHSAS) continues to review and improve its practices in pursuit of recovery supportive services in the least restrictive setting possible for the individual being served.

ATTACHMENTS:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Office of Mental Health and Substance Abuse Services, Bureau of Policy, Planning & Program Development, P.O. Box 2675, Harrisburg, PA 17105. General Office Number 717-772-7900.

Attachment 1: Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers

Attachment 2: County Service Area Designations

Attachment 3: Regional Forensic Psychiatric Center Pre-Admission Referral

Attachment 4: Certification of Need for Persons under the Age of 22 or Over the Age of 65

Attachment 5: Standard Notification Letter

Attachment 6: Emergency Regional Forensic Psychiatric Center Admission Report

RELATED BULLETINS:

99-84-24: Continuity of Care

99-83-42: Guidelines for Voluntary and Involuntary Patients Refusing Physical Examination on Admission

SMH-95-01: Crime Victim Notification: Implementation of Amendments to Act 155; Expanding the Bill of Rights for Victims of Crime

SMH-P-12-01: Unsupervised Leave of Persons Found NGRI

SMH-P-12-04: Information Sharing Between Regional Forensic Psychiatric Centers and State or County Correctional Facilities upon Admission and Discharge

OBSOLETE BULLETINS:

This bulletin obsoletes the following OMHSAS Bulletins:

- SMH-P-12-05: Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers
- 99-83-25: Referral Procedures for “Guilty But Mentally Ill” Individuals

Attachment 1

Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers

TABLE OF CONTENTS

I. FORENSIC LEVEL OF CARE

The Forensic Task Force of 1991 established one level of forensic care to replace the medium and maximum security designations of specific forensic facilities. Environmental and procedural security safeguards are in place in each RFPC to provide a secure environment to provide patient treatment and care.

Patients who have been charged with, convicted or found Not Guilty by Reason of Insanity (NGRI) of minor, non-violent offenses, who are not sentenced to the jurisdiction of the Department of Corrections and who, as determined by the committing court, do not require the security of the RFPC, may continue to be admitted to civil units at state hospitals.

A centralized referral process will include a concurrent review of individuals for diversion to other housing and services including least restrictive treatment settings appropriate to the patients' clinical and security needs.

The RFPCs are designed to provide psychiatric care and treatment for persons who have involvement in the criminal justice system. They are not a long-term placement option. RFPCs offer the following inpatient services:

A. Evaluation for competency to stand trial.

B. If necessary, psychiatric care and treatment to restore competency.

C. Mental health care and treatment to persons who have been found NGRI of criminal offenses enumerated in the Mental Health Procedures Act.

D. Mental health care and treatment in a secure facility for persons subject to detention in county or municipal jails.

E. Inpatient examination to assist with sentencing and disposition of persons who have been criminally convicted and are awaiting sentencing.

II. CRITERIA FOR ADMISSION

Under section 401(a) of the Mental Health Procedures Act (MHPA), a person who is charged with a crime or undergoing sentence and who is or becomes severely mentally disabled as defined by section 301 of the MHPA may be subject to commitment proceedings for involuntary mental health care and treatment as if he or she were not charged or sentenced. In addition, under section 402 of the MHPA, a court may order involuntary examination and treatment for competence to stand trial.

Persons will be admitted to RFPCs only as ordered by a court. The following court orders will authorize admission to an RFPC:

A. A court order issued under section 304 or 305 of the MHPA for persons who are subject to detention in county or municipal jails.

B. A court order issued under section 304 or 305 of the MHPA for persons who are incarcerated at the State Correctional Institute (SCI) – Muncy. OMHSAS will allocate three forensic beds for this purpose. No other SCI inmates will be admitted to RFPCs.

C. A court order issued under section 304 of the MHPA for a person who has been found Guilty But Mentally Ill (GBMI).

D. A court order issued under section 304(g)(2) of the MHPA for persons who have been found incompetent to be tried or NGRI the following offenses:

1. Murder
2. Voluntary manslaughter
3. Aggravated assault
4. Kidnapping
5. Rape
6. Involuntary deviate sexual intercourse
7. Arson

E. A court order issued under section 402 of the MHPA for treatment to restore competence to stand trial or evaluation to determine competence to stand trial. Persons committed to state hospitals pursuant to section 402 of the MHPA may receive competence evaluation and treatment to restore competence in settings other than a RFPC as ordered by the court.

III. PERSONS WHO MAY NOT BE ADMITTED OR TRANSFERRED TO A RFPC.

A. The following persons are not eligible for admission to a RFPC, even if they are severely mentally disabled as defined by section 301 of the MHPA, unless they meet one of the criteria specified in Section II, A - E.

1. Persons who are not formally charged with a crime or serving sentence, even those patients who are assaultive or difficult to treat;
2. Persons who have been tried and acquitted of a criminal offense;
3. Defendants against whom charges have been withdrawn, *nolle prossed* or dropped;
4. Persons charged with a crime but released on bail at the time the initial mental health commitment is initiated;
5. Persons convicted of crimes and who have been paroled and against whom no new detainers have been filed;
6. Persons convicted of crimes and placed on probation and against whom no new detainers have been filed;
7. Persons found NGRI on charges other than those listed in Section 304(g)(2) of the MHPA;
8. Persons subject to court ordered commitments pursuant to Section 302 and 303 of the MHPA;

9. Persons sentenced to serve their terms of imprisonment in a SCI operated by the Pennsylvania Department of Corrections.

When persons do not meet the criteria for admission to the RFPC, but still require inpatient psychiatric care and treatment, they should be admitted to a community treatment setting or the civil unit of a state hospital.

B. RFPCs are certified by the Centers for Medicare and Medicaid Services as parts of psychiatric hospitals. They are not primary medical care facilities and are unable to provide complex medical care to patients who need such care to maintain their health and safety. Therefore, patients with the following conditions are not appropriate for admission to RFPCs:

1. Unconsciousness or semi-consciousness.
2. Recent heart attack or stroke.
3. Delirium from any organic brain disorder; e.g., alcohol or drug toxicity, lithium toxicity, or metabolic syndrome.
4. Neurocognitive disorders.
5. Impending alcohol or drug withdrawal. Patients who are on methadone maintenance may be admitted under the state hospital protocols.
6. Serious fractures requiring specialized rehabilitation.
7. Need for artificial respiration or other life support systems.
8. Advanced Chronic Obstructive Pulmonary Disease in the final stages requiring special isolations and protection.
9. Need for intravenous medications including antibiotics.
10. Need for primary nursing care or nursing home level of care or similar setting.

IV. SERVICE AREA DESIGNATIONS

A. County service area designations for RFPCs have been revised to provide access to beds by each county, according to the county's historical admission needs and or census data and population demographics. County service area designations for each RFPC are appended to this Policy (**Attachment 2**).

B. Three (3) female beds will be available at a RFPC as determined by DHS for use as needed by inmates incarcerated at SCI - Muncy.

V. RFPC REFERRAL PROCESS

A. Each county should identify a point of contact regarding referrals coordination.

B. Whenever an individual is referred to an RFPC, the correctional facility will complete RFPC Pre-Admission Referral form. (**Attachment 3**).

C. The Pre-Admission Referral form, the Mental Health Commitment or Court Order, and information to support the referral will be sent by registered mail, secure fax, scan, or an alternative method such as in person delivery.

D. A certificate of need is also necessary for all patients under the age of 22 or over the age of 65. (**Attachment 4**)

E. An incomplete referral will result in the Standard Notification Letter and Pre-admission Referral Form being returned to the referral source with the identification of the missing referral information, (**Attachment 5**). Incomplete referrals will result in a delay in admission to the RFPC.

F. When the RFPC receives notification of a pending commitment and the request for admission of a person serving a sentence in a SCI or county correctional facility, the referral packet should contain, a copy of the criminal sentencing sheet containing the expiration dates of both the minimum and maximum sentences.

G. Once the packet is complete, the individual will be placed on a RFPC wait list.

H. Patients will be admitted to the RFPC designated for their service area based on their place on the waiting list.

I. Court orders requiring expedited emergency admission will be reviewed by the OMHSAS Centralized Forensic Coordinator for further disposition.

VI. EMERGENCY FORENSICS ADMISSIONS EXCEPTION PROCEDURE

RFPCs recognize that there are individuals whose illness has presented the need for emergency treatment within the RFPCs and it is important to admit them as expeditiously as possible to ensure that they receive the appropriate care.

A. Exception Criteria:

1. Individual must be medically clear and not in a state of detoxification; and
2. Individual is rapidly deteriorating during incarceration; or
3. Individual is acutely suicidal; or
4. Individual is a danger to other inmates (extremely violent individuals may not be able to be managed on a forensic unit thus these cases may require further discussion).

B. Process for Expedited Admission:

1. All necessary forms and attachments for admission to a RFPC must be provided, as detailed in the Regional Forensic Psychiatric Center Pre-Admission Referral **(Attachment 3)**.

2. In addition, a copy of an “Emergency Forensic Psychiatric Center Admission Report” **(Attachment 6)** detailing the Exception Criteria will be submitted to

the OMHSAS Centralized Forensic Coordinator along with the completed Regional Forensic Psychiatric Center Pre-Admission Referral.

3. If there is disagreement on the individual meeting the Exception Criteria, the case is reviewed by the facility Chief Medical Officer and if there is still disagreement, a final determination is made by the OMHSAS Medical Director.

VII. TRANSFERS FROM RFPCs:

RFPCs are not intended to be long-term placement options. Persons should be transferred out of RFPCs whenever their legal and clinical status warrant a different level of care or security.

Events Triggering a Transfer From a RFPC:

The following events in a criminal case will lead to a transfer from the RFPC.

A. Dismissal, withdrawal or *nolle prosequi* of criminal charges for a reason other than a finding of incompetence to stand trial.

B. Dismissal of charges upon a finding of incompetence to stand trial, except when the patient was charged with an offense listed in section 304(g)(2) of the MHPA.

C. Dismissal of charges after the expiration of a stay of proceedings as specified in section 403(f) of the MHPA, except when the patient was charged with an offense listed in section 304(g)(2) of the MHPA.

D. Conviction or guilty plea of charges for which the sentence does not include incarceration.

E. Conviction or guilty plea of charges, except when the patient is found Guilty But Mentally Ill (GBMI) and committed for involuntary mental health care and treatment. (304 or 305)

F. Acquittal of criminal charges for any reason other than NGRI.

G. Acquittal of criminal charges for NGRI, except when the patient was charged with an offense listed in section 304(g)(2) of the MHPA.

H. Expiration of maximum sentence. This event is likely to be known well in advance of its occurrence. Therefore, planning for or transfer of the patient whose maximum sentence is expiring should begin as soon as the patient is admitted.

RFPC Procedures For Transfers

A. Before any transfer may occur, the RFPC must receive a written order issued by the court having criminal jurisdiction that the patient is no longer subject to criminal detention.

B. The RFPC will adhere to all established transfer procedures, and will notify all involved parties of the date and location of transfer.

C. If an individual who has been committed from a county or municipal jail, or who has been found GBMI, is no longer in need of state hospital level of care, the RFPC will return the patient to the custody of the appropriate county or municipal jail.

D. When the RFPC receives notice that an individual will no longer be subject to criminal detention, it will make a determination of appropriate level of care or placement to meet the needs of the patient.

Transfer of Patients From RFPC to Civil Units of State Hospital

A. When a patient in a RFPC no longer meets criteria for admission to the RFPC, but still requires a state hospital level of care, the patient may be transferred to a civil unit in the state hospital whose catchment area includes the patient's county of residence, provided that there is a valid commitment order from the court for continued involuntary mental health care and treatment.

B. The civil unit of a state hospital can only provide the same degree of security for patients transferred from a RFPC as it does for other patients in the civil unit.

C. The RFPC will be responsible for arranging transportation of the patient to the civil unit on the date of transfer.

D. This transfer will occur within a reasonable time period.

Transfer of Patient to the Community

A. When the court having criminal jurisdiction authorizes transfer from the RFPC to the community under a Community Support Plan (CSP) or home plan, or criminal charges have been resolved, coordination will occur to address the clinical needs of the individual if mental health treatment is needed. Alternative community options may be pursued.

B. If an individual is found to no longer need state hospital level of care, the RFPC will follow the continuity of care policies for discharge; which at the minimum will include a discharge plan.

C. A RFPC will not discharge a patient who is subject to involuntary commitment pursuant to section 304(g)(2) of the MHPA without first providing notice and filing a petition for conditional or unconditional discharge with the court of criminal jurisdiction pursuant to section 304(g)(4) of the MHPA

Transfers of Persons between RFPC's

In extraordinary circumstances, OMHSAS may transfer an individual between RFPCs. When determination is made that a transfer of a person at an RFPC is appropriate, and approved by the court of criminal jurisdiction, the transfer arrangements will be made between the RFPC's. Once this transfer occurs, the RFPC where the patient originated will notify the court of criminal jurisdiction.

VIII. RESPONSIBILITY FOR IMPLEMENTATION

The Director of Community and Hospital Operations of OMHSAS will resolve any disagreements among state hospitals and RFPCs arising in the course of the transfer process, and will be responsible for ensuring transfers occur within a reasonable timeframe.

IX. REFERENCES:

The Mental Health Procedures Act, 50 P.S. §§ 7101-7503

55 Pa. Code Chapter 5100, relating to "Mental Health Procedures"

Attachment 2

County Service Area Designations

Regional Forensic Psychiatric Center at Torrance

Allegheny
Armstrong/Indiana
Beaver
Bedford/Somerset
Blair
Butler
Bradford/Sullivan
Cambria
Cameron/Elk/McKean
Centre
Clarion
Clearfield/Jefferson
Columbia/Montour/Snyder/Union
Crawford
Cumberland/Perry
Dauphin
Erie
Fayette
Forest/Warren
Franklin/Fulton
Greene
Huntingdon/Mifflin/Juniata
Lawrence
Lycoming/Clinton
Mercer
Northumberland
Potter
Tioga
Venango
Washington
Westmoreland
York/Adams

Regional Forensic Psychiatric Center at Norristown

Berks
Bucks
Carbon/Monroe/Pike
Chester
Delaware
Lancaster
Lebanon
Lackawanna/Susquehanna/Wayne
Lehigh
Luzerne/Wyoming
Montgomery
Northampton
Philadelphia
Schuylkill

Attachment 3

Regional Forensic Psychiatric Center Preadmission Referral

In order to be considered a complete referral to the RFPC, and thus to be placed on the waiting list, the RFPC Preadmission Referral Form must be completed and asterisked items must be submitted at a minimum. All remaining documentation must be submitted for review prior to scheduling for admission.

Name: Last Name, First Name, and MI **Maiden Name**: Click here to enter text.

AKA: Click here to enter text.

Municipal or Common Pleas Court Number: Click here to enter text.

Home Address Prior to Incarceration: Address, City, State, Zip Code

☐ Male ☐ Female

SS#: Click here to enter text. **Marital Status**: Click here to enter text. **Religion:** Click here to enter text.

Date of Birth: Click here to enter text. **Age:** Click here. **Occupation**: Click here to enter text.

Veteran: ☐Yes ☐ No **Branch:** Click here to enter text.

Does the Person Speak English? ☐Yes ☐ No

Primary Language other than English: Click here to enter text.

Sensory Problems? ☐ Hard of Hearing ☐ Deaf ☐ Visual Impairment ☐ Blind

Level of Education: Click here to enter text. ☐ **New Admission** ☐ **Readmission**

Date of Last Discharge Click here to enter a date. **Unit:** Click here to enter text.

County of Residence: Click here to enter text. **Committing County:** Click here to enter text.

County of Sentence: Click here to enter text.

MH Commitment ***(check all that apply)*** ☐304 ☐304g2 ☐GBMI ☐305 ☐402 ☐403 ☐405

Other ***(Please clarify)*** Click here to enter text.

Most Recent MH Commitment Date: Click here to enter a date.

Effective Date: Click here to enter a date. **Duration:** Click here to enter text.

Reason for Referral as Written on the Court Order:

Click here to enter text.

Charges: Click here to enter text.

Date of Incarceration: Click here to enter a date.

Is Person Currently Sentenced? ☐Yes ☐ No **Max Out Date:** Click here to enter a date.

Anticipated Court Date: Click here to enter a date.

Judge: Click here to enter text. **Phone Number:** Click here to enter text.

Defense Attorney: Click here to enter text. **Phone Number**: Click here to enter text.

Medical Department Contact: Click here to enter text. **Phone Number**: Click here to enter text.

Community Behavioral Health Contact: Click here to enter text. **Phone Number**: Click here to enter text.

Base Service Unit/Service Coordination Unit Prior Mental Health Services: ☐ Yes ☐ No If Yes, Click here to enter text.

Name: Click here to enter text.

Phone Number: Click here to enter text. **Work:** Click here to enter text. **Cell:** Click here to enter text.

Date Behavioral Health Notified of Referral to RFPC: Click here to enter a date.

Psychiatric/Medical Diagnosis (es) – *Please enter all know conditions*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.

Reason for Incompetency if Found Incompetent: Click here to enter text.

High Risk Behavior *(Past/Present)*

☐ Suicide Attempt(s); Date(s); Method(s): Click here to enter text.

☐ AWOL History ☐ Self-Mutilative ☐ Homicidal
☐ Anorexic ☐ Self-Abusive ☐ History of Fire Setting
☐ Polydipsia ☐ Assaultive/Destructive ☐ Sexually Aberrant Behavior
☐ PICA ☐ Uncontrolled Seizure Disorder

Other (Please be specific): Click here to enter text.

Current Medications *(Psychiatric & non-psychiatric)* List below or attach MAR.

Is MAR attached? ☐ Yes ☐ No

Name Of Medication	Dosage	Reason for Medication	Start Date	Takes Meds Yes/No

Name: Click here to enter text.

Over the Counter Medication or Herbal Supplements: Click here to enter text.

Drug Allergies *(Specific Reaction)*: Click here to enter text.

Food Allergies *(Specific Reaction)*: Click here to enter text.

Special Diet: Click here to enter text.

Environmental Allergies: Click here to enter text.

Physical Problems *(Including injury (ies); chronic pain; sensory limitation or others as noted):*
Click here to enter text.

Any current/acute/chronic infectious disease: ☐Yes ☐ No
If yes, explain: Click here to enter text.

Ambulation: ☐ Unaided ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Prosthesis
Specify: Click here to enter text.

Immunizations (Include PPD) List Below or Attached ☐Yes ☐ No	**Date Administered**

Recent Psychological Tests: ☐ Yes ☐ No *Date of Report:* Click here to enter a date.

Prior Psychiatric Hospitalizations:

Location	**Dates**

Drug, alcohol and nicotine history: Click here to enter text.

Drug, alcohol and nicotine treatment history: Click here to enter text.

Advanced Directives: *Medical:* ☐Yes ☐No *Psychiatric:* ☐Yes ☐ No

Organ Donor: ☐Yes ☐No

Income: ☐Yes ☐No *Source:* Click here to enter text. *Amount:* Click here to enter text.

Medical Insurance Information: Click here to enter text.

Name: Click here to enter text.

Medical Assistance Number: Click here to enter text. **Medicare Number:** Click here to enter text.

Medicare D Plan: Click here to enter text. **ID:** Click here to enter text.

Next of Kin/Significant Others:

(1) Name: Click here to enter text. Relationship: Click here to enter text.
Address: Address, City, State, Zip Code
Phone: Home Phone: Work Phone: Cell

(2) Name: Click here to enter text. Relationship: Click here to enter text.
Address: Address, City, State, Zip Code
Phone: Home Phone: Work Phone: Cell

The Following Documentation is required

1. *Affidavit of Probable Cause ☐ *Criminal Complaint ☐ *Police Arrest Record ☐
2. * Court Order ☐
3. Sentencing Sheet ☐
4. Copies of Assessments:

*Psychiatric	☐Included	☐Not Included/Reason Click here to enter text.
Nursing	☐Included	☐Not Included/Reason Click here to enter text.
*Medical	☐Included	☐Not Included/Reason Click here to enter text.
Psychological testing	☐Included	☐Not Included/Reason Click here to enter text.
Psycho-social	☐Included	☐Not Included/Reason Click here to enter text.
Competency Evaluation	☐Included	☐Not Included/Reason Click here to enter text.
Other Disciplines involved in patient's care	☐ Included	☐Not Included/Reason Click here to enter text.

5. Copies of reports:
   - ☐ Consultations
   - ☐ Laboratory Reports and/or other medical studies performed including
   - ☐ Chest x-ray; EKG; EEG; HIV; Hepatitis; TB; CBC; SMAC; WBC; PPD
   - ☐ Medication related blood levels
6. *Copies of Progress notes and Physician's Orders for at least the last three weeks ☐
7. Copy of current Treatment Plan ☐
8. Certificate of Need Attached if under age 22 or 65 and above? ☐Yes ☐ No

Signature of Person Completing the Form: _____ Date: Click here to enter a date.

Printed Name/Title: Click here to enter text. Phone Number: Click here to enter text Email: Click here to enter .

Please fax completed referral to: Click here to enter text.

Or via encrypted email completed referral to: Click here to enter text.

At email address: Click here to enter text.

Attachment 4

CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC HOSPITALIZATION OF A PERSON UNDER THE AGE OF 22 OR OVER THE AGE OF 65

Date: _____

The undersigned members of the Psychiatric Treatment Team at the

_____ hereby certify that
(Name of Referring Agency)

_____, requires psychiatric treatment on an
(Patient)

inpatient basis. We have examined said patient and find that:

1. The ambulatory care resources in the community do not meet the needs of the patient; and

2. Inpatient treatment under the direction of a physician is required; and

3. The provision of such services can reasonably be expected to improve the patient's condition or to prevent further regression so the services will no longer be needed.

_____	_____
Psychiatrist/Physician	Name & Title
_____	_____
Psychologist	Name & Title
_____	_____
Social Worker, Registered Nurse or Occupational Therapist	Name & Title

Ref. Authority 42 C.F.R. 441, Subpart D.

Attachment 5

pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Date:

To: _____
(Referring Person and Agency)

The RFPC Referral and/or Court Order for the Admission of _____
(circle one) *(Name)*
to the RFPC was received on _____.
(Date)

In order to assure complete and thorough evaluation of the referral, in addition to adequately addressing any medical concerns or safety/security measures related to the individual, the following items that were not included must still be provided:

_____ The Court Order

_____ RFPC Referral Form Information: _____

_____ Affidavit of Probable Cause

_____ Criminal Complaint

_____ Police Arrest Record

_____ Assessments: _____ Psychiatric Evaluation _____ Nursing _____ Medical
_____ Psychological testing _____ Psycho-Social

_____ Competency Evaluation

_____ Other Assessments/Screens: _____ Laboratory Reports _____ Chest X-Ray
_____ Hepatitis Screen _____ HIV Test
_____ Medication Related Testing _____ PPD

_____ Medication Administration Record

_____ Progress Notes *(for at least weeks)*:_____

_____ Current Treatment Plan

_____ Certificate of Need under age 22 or 65 and over

Once the specified materials are received the individual will be placed on the RFPC wait list for admission. The materials may be submitted electronically, mailed or personally delivered to the attention of: _____. Please direct all questions to
(Name)
_____, at _____ or via email at _____
(Name) *(Phone number)* *(email address)*

Sincerely,

_____, *CEO*

_____*State Hospital*

2/2016
Attachment 6

Emergency Regional Forensic Psychiatric Center Admission Request

Name of Individual for whom Emergency Referral is being Requested:

_____

Name of Person requesting Emergency Referral:

_____ _____
(Title)

Date of Request:_____

___RFPC Referral Preadmission Form Attached

___The individual has been medically cleared and is not requiring medically monitored detoxification

Name of Practitioner providing medical clearance: _____

Reason for Request: (Check all that apply but must meet at least 1 criteria, also must be medically cleared and not requiring medically monitored detoxification)

___Rapid deterioration of individual during incarceration, or

___Acutely suicidal individual, or

___Individual is a danger to other inmates (extremely violent individuals may not be able to be managed on a forensic unit thus these cases may require further discussion)

Signature of Person completing the Emergency Request**:** _____

Date: _____